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PSYCHIATRIC ABSTRACTS SERIES NO. 8
CROSS-CULTURAL ASPECTS OF SCHIZOPHRENIA WITH EMPHASIS ON
CULTURAL VARIATIONS IN THE FAMILY STRUCTURE

A SURVEY OF THE LITERATURE

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PSYCHIATRIC ABSTRACT SERIES

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Introduction

CROSS-CULTURAL ASPECTS OF SCHIZOPHRENIA WITH EMPHASIS ON CULTURAL VARIATIONS IN THE FAMILY STRUCTURE

Of recent years a gradually increasing awareness of the far-reaching effects of schizophrenia and its impact upon the cultural and social matrix of individual, family, and group behavior has indeed become apparent. This bibliography, the 8th in the Psychiatric Abstracts Series, reports in abstract form the incidence, symptomatology, and other characteristics of schizophrenia as seen in a number of cultures. At present, comparative data on schizophrenia in different cultures are woefully inadequate. With this in mind, the compiler presents these summaries as a small contribution, a token index so to speak, to the literature on schizophrenia and its cultural relationships. The rationale behind this search is threefold: (1) to supply the interested psychiatrist, psychologist, and sociologist, already overburdened with a profusion of irrelevant literature, with material pertinent to his work; (2) to supply other workers in these disciplines with background material for use at a future time; (3) to facilitate the dissemination of knowledge about people and the way in which they live and behave, in an attempt to bring these people together in a better understanding.

It should be pointed out that this bibliography is in no way definitive. It serves only to present a cross section of the journal literature on the Cross-cultural Aspects of Schizophrenia. The references included herein were dependent on the compiler's judgement and were selected to present a picture of this subject from 1955 to date, with emphasis being placed on the latter years. The arrangement is by culture. A numerical breakdown is given for identification purposes only. Within each culture category, there is an alphabetical breakdown by author's surname. An Author-Contents index as well as a directory of cultures prefaces the Work.

The compiler wishes to express his gratitude and appreciation to Dr. Lyman C. Wynne for his help, guidance and criticism in the preparation of this survey.

Francis D. Horigan

(December 1961)

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001 -- AMERICAN INDIAN -- APACHE, UTE AND ALASKAN

Opler, Marvin K.

Epidemiology of mental health

McGILL UNIVERSITY REVIEW AND NEWSLETTER (Montreal, P.Q.)

10:16-17 (Apr. 1960)

Outlines a 4 page summary of Dr. Opler's work in the epidemiology of mental health. The summary concerns two major topics: (1) the relation of culture to personality and mental illness; and (2) the etiology and development of schizophrenias within different social classes of a culture. As regards (1) Culture, personality and mental illness, Opler's field experience with several American Indian tribes (Apaches, Utes, and Alaskan Indians) and American settlers in the West convinced him that a radical cultural relativism in which each culture produces its own special and unique kind of mental illness was incorrect. There is a wide range of mental illnesses in each cultural setting. On the other hand, there is a dynamic relationship between a culture and a type and incidence of mental illness. Operationally, mental disorders are not uniform entities, immutable in time and place. "This is the great error in the Krapelinian nomenclature." (2) Schizophrenia: Here the author describes the schizophrenic manifestations and compares them with those of the echolalia-echopraxia, latah, imu and amok varieties. These Indian types are functionally different from the so-called Western man. He believes that differences are due to the different types of stress symptoms found in the different cultures. They are functionally different from Western forms. As a matter of fact, the schizophrenias of Irish and Italians are also surprisingly different from each other.

002 -- _____ -- CHIPPEWA

Friedl, Ernestine

Persistence in Chippewa culture and personality

AMERICAN ANTHROPOLOGIST 58:814-25 (Oct. 1956)

Reviews some of the phases of Chippewa history which suggest that the conditions of Chippewa history and aboriginal culture were conditions of change. For the individual Chippewa, the expectation that any given situation will be unique and short-lived in its consequences may well have resulted from these conditions of incessant change. Such an expectation is congruent with the development of a detailed, practical and noncreative approach to problems. Finally,

these conditions of change are such as have been maintained throughout Chippewa acculturation history, thus making it possible for the same expectations to continue and for the same approach to problems to continue to have some adaptive value.

By and large, it may be said that the author has made no attempt to show or make apparent interrelations between personality traits and conditions of culture. The present paper considers culture as it undergoes considerable change on its overt or explicit level. At the same time, it may be maintaining continuity of another sort, continuity of covert culture, or as some investigators call it "continuity of implicit culture." In the case of the Chippewa, the all pervasive condition of change in which the forms of culture functioned, and the resulting view of human events may be termed a covert or implicit characteristic of Chippewa culture. If it can be demonstrated that certain personality traits persist simultaneously with certain patterns in the covert characteristic of a culture, it then becomes necessary to search for the social or psychological mechanism by which the two might be connected. Since the continuity of many Southern Chippewa personality traits in the face of rapidly changing culture has posed a problem in personality and culture studies, it is hoped that pointing out a possible connection between implicit cultural characteristics and personality traits may be helpful for further analysis of the problem.

003 -- ARABIA

Parhad, Luther

Report from Kuwait

MCGILL UNIVERSITY REVIEW AND NEWSLETTER (Montreal)

9:36-37 (Dec. 1960)

Presents an abstract of a letter written by the author on July 20, 1958. The author states that observations made by writers from Japan and India on the passivity, non-aggressiveness and non-destructiveness of hospitalized patients corresponds to what can be seen here (in Kuwait) and in all the Arab countries. Characterologically speaking, most of the male population in these cultures are passively aggressive, and it is this basic character which is reflected in psychoses as negativism, inactivity, and indifference.

Dr. Parhad has finished a study on the psychiatric illnesses among the ruling family of Kuwait. This family has over

300 living members and is more than 200 years old. For all that period it has maintained a pure blood, as far as marriage is concerned, and among the 300 living members, there is not one case of schizophrenia. Too, the author has not been able to trace a single case of schizophrenia among the deceased generations. He has, however, found other psychiatric illnesses, such as personality disturbances, neuroses, sociopathic cases, but no schizophrenia. Furthermore Dr. Parhad is now studying the family structure in detail together with the manner in which children are reared from date of birth. The object relationship in these newcomers to the family develops uninterruptedly, smoothly, and very securely during their formative years.

004 -- ARGENTINA

Redlich, F. C.

Social class, culture and schizophrenia

ACTA NEUROPSIQUIATRICA ARGENTINA 3:336-40 (1957)

Summarizes existing knowledge concerning the influence of social class and culture on the incidence, prevalence, phenomenology, etiology and treatment of schizophrenia. To date, no definite data on incidence of schizophrenia are available. Existing data on incidence are not based on representative samples of the population. Prevalence data have been obtained by more adequate methods, but are less satisfactory for epidemiological survey than incidence data. As no truly satisfactory epidemiological data on mental illness exist in any culture, cross-cultural comparison, relating incidence and prevalence to social variables, cannot be presented with any degree of accuracy. About the only thing that is known is that schizophrenia occurs in all strata of society. No systematic knowledge exists as to the manner in which culture variables influence the phenomenology of schizophrenia. This syndrome is more or less similar rather than dissimilar. The etiology of schizophrenia is obscure and no single etiological factor can be ascribed to its causation. The highest incidence of schizophrenia is to be found in urban slum areas. It is interesting to note that rarely in the best or better run of hospitals, extremely regressed schizophrenics are to be seen, while the agitated and seriously deteriorated cases are frequently found in the back wards of unsatisfactory hospitals. Attempts at social rehabilitation of schizophrenics are extremely unsuccessful and these patients are more than apt to remain in institutions. Dr. Redlich believes that certain aspects of mental hospitals as they

(ARGENTINA -- contd.)

exist today are unfavorable for schizophrenics particularly those in public mental hospitals. The hospitals isolate and inactivate rather than reunite and activate. Although today's institutional therapy of schizophrenia is inadequate, it is hoped that a better understanding of the present patterns of interaction of therapists, patients and families will lead to better therapeutic results.

005 --

Sbarbi, S.

Contribucion al estudio de la moribilidad mental...en Argentina
A contribution to the study of mental morbidity...in Argentina
REVISTA DE PSYQUITRIA DEL PERU 2:128-31 (#2, 1959)

Presents several reasons which effect the investigation of mental morbidity in the Argentine. Many cases of simple schizophrenia and mental deficiency do not receive aid in rural areas because they are not considered ill or do not present serious problems to their families. Mental disease is attributed to superstitious causes and is therefore not reported. A large number of psychiatric cases are treated by quacks or spiritualism centres. Large areas in Argentina are not supplied with psychiatric facilities. In the past 15 years, the migration to the cities has increased considerably. Schizophrenia psychoses seem to be more frequent in urban areas than in the country.

006 -- AUSTRALIA -- MAORI

Blake-Palmer, G.

Maori attitudes to sickness

MEDICAL JOURNAL OF AUSTRALIA 2:401-05 (Sept. 15, 1956)

Explores the relationship between Maori (the native polynesian of New Zealand) personality, culture patterns and mental illness. The admission rate of Maoris to mental hospitals is significantly lower than the European rate. In 1953, the Maori rate was 20.61 per 10,000 while the European rate was 47.73 per 10,000. The numerical incidence of schizophrenia is roughly the same as that of the European population, though the content of the disorder shows some cultural patterning.

Blake-Palmer points out that research should be directed toward showing how culture patterns protect the Maori from his heavy load of anxiety and insecurity. Some of these patterns involve kinship, tribal and community organization, child rearing practices, easier acceptance of maternity, freer patterns of adolescent and premarital sexual mores and belief in the supernatural.

Stainbrook, Edward

Some characteristics of the psychopathology of schizophrenic behavior in Bahian society

AMERICAN JOURNAL OF PSYCHIATRY 109:330-35 (Nov. 1952)

Describes social organization and interaction within the Juliano Moreira State Psychiatric Hospital located in San Salvador, the capital of Bahia. The psychological distance between psychiatrist and patient, based largely on the social class and hospital role difference, was striking.

After the acute admission phase of their illness, low-class patients particularly, generally related to the physician by passive and submissive attitudes. The unhesitating obedience of many schizophrenic patients was especially noticeable. So, too, as in East Indian schizophrenic behavior, overt impulsive and aggressive activity on the part of the patients toward any of the hospital personnel was very little in evidence. Such behavior, however, may be due to the characteristics of the hospital organization rather than to culturally determined differences of personality.

Women were much more prone to express their aggressive and other fantasies than were men. On the other hand, even the most acutely disturbed women retained their early habits of modesty, arranging their dress between their legs when squatting in the habitual sitting position.

This is more open expression of ideation and feeling by female psychiatric patients and may probably be based on the child rearing differences in the severity of discipline related to learning how to satisfy sexual and aggressive needs and on the cultural patterns of action for male and female behavior.

Approximately 85% of the hospital patients were socially of the lower class. From the ethnic point of view, Bahians generally represent a "multiracial" class society. These classes are still largely identified with color, but they are classes and not castes. The most characteristic tendency of the Bahian social order is the gradual but persistent reduction of all distinguishing racial and cultural marks and the fusion biologically and culturally, of the African and European into one race and one common culture. The hospital population was predominantly blacks and mixed bloods, largely illiterate, and a majority exhibited behavior patterns, for the most part, in religion demonstrating both European and Brazilian influences.

Montagu, Ashley

Culture and mental illness

AMERICAN JOURNAL OF PSYCHIATRY 118:15-23 (July 1961)

Points out that contemporary psychiatric theory and the development of modern cultural anthropology evolved at about the same time. In his paper on culture and mental illness, the author not only discusses the influence of culture on mental illness, but also the influence of mental illness on culture. This latter approach is one which has received altogether too little attention. Schizophrenia tends to be the mental disease most common among social isolates such as unskilled workers, farmers, or lone urban residents. Manic depressive illness, on the other hand, is the condition prevalent among professional, religious, socially prominent and other groups of persons, who have strong idealistic, interpersonal and community involvements.

Clear-cut evidence involving the relationship between culture and mental illness is to be found in a culture flourishing in our very midst -- namely, the HUTTERITES. Among this sect there is a generally prevailing atmosphere of relaxation, contentment, cooperation and manifest equanimity with a positive loss of anxiety. In 1951, it was found that of a total population of 8,542 Hutterites, 199 or 1 out of every 43 were mentally ill. Out of this 199 only 8 were found to have schizophrenia. Such findings have led to the formulation of the hypothesis of specific cultural relevance with respect to the epidemiology of schizophrenia. Withdrawal in so close-knit a group as the Hutterites is difficult. This fact may readily explain the paucity of schizophrenics in this group. Among the Hutterites, no cases of psychoses due to drugs, alcohol, or syphilis have been known to occur. There were no psychopathic personalities, no cases of murder, arson, serious assault, or sex crimes. This has been explained by the generalization that Hutterites tend to internalize their problems rather than to project them into their relationships with others. Under stress they may seem to be anti-self rather than antisocial. This emphasizes submission of the individual to community expectations, the principle of personal guilt and pacifism. In such a community, schizophrenia is the disorder of social isolates while manic depression is the disorder of the socially involved.

It seems evident that all present-day humans at some time during their early development, possess the potentialities for behaving in schizophrenic, manic, obsessive or anxiety

patterns. In certain cultures, mental patients are institutionalized, which means not that the individual is placed into an institution but that he and his behavior are incorporated into the society as a normal part of it.

The author also considers the Balinese culture, one in which food and materials are adequate, war and crime are at a minimum, the arts are highly developed, and the traumatizing experience of childhood tends to turn the Balinese into schizoid personalities. From about 5 or 6 months of age and steadily becoming more definite as the child grows older, the mother continually tantalizes the child. She stimulates him to show emotion, love or desire, jealousy or anger, and then turns away as the child in rising passion ragingly and despairingly implores emotional response from her. The discouragement of interpersonal emotion is systematic. The child never attains a climax of emotional response, and the resulting withdrawal is seen in a lack of responsiveness which is already established by the age of 3 or 4. The relationship to people remains distant, wary of the expression of too much feeling. When frightened, the Balinese falls into a soft sleep from which it is difficult to wake him. On tests, the Balinese respond like schizophrenics yet they are fully functional members of their community. The important thing to note here is that in Bali, the schizoid habitus has become institutionalized, and that it has given the Balinese culture its essential character in the arts, in interpersonal relations and in religion. Thus, we begin to see how mental illness may, to a great extent condition the institutionalized forms of emotional expression, such as religion, pageantry, painting, carving, puppet-making, music and dance, drama, narrative and the like.

The comparative psychiatry of cultures and of nations is a fascinating topic. We stand much in need of social psychiatry which will devote itself to the study of the causes and cure of mental illnesses of cultures.

009 -- BURMA

Grewal, R. S.

Mental disorders in Burma (Rangoon)

MCGILL UNIVERSITY REVIEW AND NEWSLETTER 6:20-21 (July 1959)

Presents a preliminary draft of a thesis by the author in which he outlines some of the more interesting of his observations. The commonest of disorders admitted to Tadagale Mental Hospital in Burma is a violent form of manic depressive psychoses with excitement, hallucinations of persecution or of a sexual nature, cheerfulness, obstinate constipation, and eventual

exhaustion. The author states that "Onset seems to have some relation to the phases of the moon," and the outcome does not appear to be much better than in cases presenting a schizophrenic picture.

Schizophrenia is characterized then by the relative rarity of catatonic and simple types, the commonest traits being delusions of persecution, initial agitation, echopraxia, contrasuggestibility and stereotypy. The average age of onset appears to be relatively late (according to Asian standards) and where a late prognosis is relatively good. As elsewhere, an acute onset is of better prognosis than an insidious one; the asthenic body-type predominates, emotions are shallow, and bizarre behavior is typical. ECT often produces good results.

In Dr. Grewal's opinion, factors in the Burmese scene which encourage mental breakdown are the low vitamin B-1 content of the diet, the rice cultivation cycle with its long periods of idleness, the high prevalence of venereal disease, gambling, and the present political insecurity and banditry in many areas. Since mental hospitals are so very few, most of the care for the mentally ill falls to Buddhist monks or traditional physicians, whose methods appear not dissimilar to certain Western schools.

010 -- CANADA

Cameron, D. E. and Pande, S. K.

Treatment of the chronic paranoid schizophrenic patient
CANADIAN MEDICAL ASSOCIATION JOURNAL 78:92-96 (Jan. 1958)

Discusses the results of combined sleep and intensive electroshock treatment with subsequent rehabilitation and follow-up ambulant therapy in chronic paranoid schizophrenia.

This therapy is based on three theories: (1) That schizophrenia represents a biological process which can be arrested by chemical and physical therapies (and also spontaneously), but which tends, particularly when of any intensity or duration, to leave behind permanent damage. (2) That recovery consists primarily in (a) halting the process, and (b) a reorganization of the individual which results in a short-circuiting or inactivation of the damaged area, but which does not result in an abolition of the estimated damage. (3) That a considerable portion of schizophrenic relapses, though certainly not all, constitute a reactivation of the process but a reorganization of the individual, usually under emotional stress....The group of patients consisted of 16 chronic paranoid patients who had symptoms of two or more years duration compared with a group of 10 paranoid schizo-

phrenic patients with symptoms of less than 2 years' duration.

Three of the long-term cases have broken off treatment and have again shown paranoid symptomatology but continue to remain outside the hospital. On the other hand, three other long-term cases were readmitted and two of these were subsequently discharged. One is still undergoing treatment. The longest period of follow-up is two years. Minor relapses occurred in several of the cases, but these were treated successfully on an ambulant basis. Not any of the short-term cases had to be readmitted. In the long-term cases some residual evidence of schizophrenia can be seen. This takes the form of reduction in drive and blunting of affect. In only three of the long-term cases (two of which had broken therapy and one who was readmitted) and in none of the paranoid cases was there evidence of paranoid thinking.

The primary objective of this study was to show wherein the authors' therapeutic procedures have advanced to the point where it is now possible for schizophrenic patients, even when subjected to the most severe forms of the illness, to pass through a phase of intensive treatment followed by long-term rehabilitative measures and thereby to live, and in many instances work outside the hospital.

011 -- CANADA -- FRENCH

Paul-Hus, Gilles

Considerations sur la schizophrénie des ruraux

Factors concerning schizophrenia in rural areas

CANADIAN MEDICAL ASSOCIATION JOURNAL 5:20-23 (Jan. 1960)

Briefly outlines some social and cultural characteristics of French-Canadian farmers examined at St. Jean de Dieu Hospital, Montreal. The usual picture is that of a young schizophrenic who after a psychosexual and physical development considered normal by his family leaves school at about the 5th grade. He is described as shy, hard-working, a heavy week-end drinker, who rarely mingles with the opposite sex. The importance of religion in his milieu can be seen in the copious amount of religious material in the content of his delusions and in the ideas of reference manifested by the patient. Identification with God is most evident. When recovered from the acute stage of the psychosis, the young schizophrenic is well received by his family.

As a result of his observations, the following suggestions are made by the author: (1) Psychoanalysis and deep psychotherapy are not indicated or successful in dealing with these patients. (2) Once the acute phase has been treated by somatic means, the patient should be returned to his home and family as soon as possible. (3) The patient's religious ideas should be given careful scrutiny in order to more fully understand his emotional problems. (4) Heredity plays an important role in that there are more consanguineous marriages. However, there is no direct evidence that this factor is especially productive of schizophrenia.

012 -- CHINA

Lin, Tsung-yi

A study of the incidence of mental disorder in Chinese and other cultures

PSYCHIATRY 16:313-36 (Nov. 1953)

Reports a study of the incidence of mental disorder in Chinese culture and compares it with that of several other countries. After making this survey, Dr. Lin cites the woeful inadequacy of comparative data in the different cultures. The census method was used in making this investigation. Three towns were selected as representative population samples for the census: Baksa, Simpo and Ampeng. The psychiatric picture of these 3 communities is shown in the following table:

MENTAL DISORDERS GROUPED ACCORDING TO TYPE

	Baksa		Simpo		Ampeng	
	Total No. of Cases	Rate per 1000	Total No. of Cases	Rate per 1000	Total No. of Cases	Rate per 1000
<u>Schizophrenic</u>						
<u>reaction</u>	10	1.8	17	2.5	16	2.1
Manic-depressive						
psychosis	4	0.7	5	0.7	4	0.5
General paresis	0	0	0	0	0	0
Senile psychoses	5	0.9	0	0	1	0.1
Other psychoses	3	0.5	5	0.7	6	0.8
Epilepsy	9	1.6	10	1.5	7	0.9
Mental deficiency	23	4.1	22	3.2	23	3.0
Psychopathic						
personality	3	0.5	5	0.7	10	1.3
Psychoneuroses	4	0.7	6	0.8	14	1.8
Alcoholism	1	0.2	0	0	1	0.1
TOTAL	62	11.1	70	10.3	82	10.9

(CHINA -- contd.)

For comparative purposes, the schizophrenic action, the first entry on the above table (underscored), was included as a main type of psychosis, despite the present-day controversy as to the content of the clinical entity of schizophrenia. The developmental history and premorbid personality, along with symptoms such as dissociation of thinking, withdrawal from reality, inappropriate emotional reaction, hallucinations, delusions, stupor and hyperkinesis were taken into consideration for diagnosis. Schizophrenic reactions were further classified as catatonic, hebephrenic and paranoid types.

In this discussion, Dr. Lin presents a few incidence figures which indicate: (1) Of all the psychoses, schizophrenic reaction showed the highest rate of incidence. (2) Schizophrenia had a higher incidence rating in urban and small town areas than in rural areas. (3) A further geographical distinction indicates that the schizophrenic reaction is concentrated near the center of populated areas. (4) Higher rates of schizophrenic reaction are to be found in females rather than males. (5) Ethnic differences in these 3 towns posed no difference in the rate of schizophrenia. (6) Educational status and the incidence of schizophrenia showed a very even distribution in contrast to results published by Dhunjibhoy, Lopes and Beaglehole which indicate that schizophrenia is more common among people having more education of a Western type. (7) The distribution of schizophrenic reaction is highly concentrated among laborers, merchants, farmers and the unemployed, whereas manic-depressive psychoses, psychopathic personality and psychoneurosis show a random distribution. (8) Considered from a socio-economic standpoint, the upper class had a comparatively high rate of paranoid schizophrenic reaction, while the lower class had a high concentration of hebephrenic reaction.

013 -- _____ -- et. al.

Yap, P. M.

Mental diseases peculiar to certain cultures: a survey of comparative psychiatry
JOURNAL OF MENTAL SCIENCE 97:313-27 (Apr. 1951)

Points out that the extension of the psychiatrist's interest to cultures other than his own demonstrated that there are basic psychological processes present in insanity everywhere, processes such as the fragmentation and regression in schizophrenia to be found in many aspects of the patient's thought and behavior. Dr. Yap mentions how primitive religion has been called "organized schizophrenia"

and the "pathology of culture." Cultural deviations from our preconceived ideas of symptomatology and diagnoses may vary from one culture to the other dependent on prevailing beliefs, customs, interests, and conflicts. For instance, if a Hindu fakir behaves much like a catatonic schizophrenic in England, he need not necessarily be insane; since not only can he begin or stop his apparently catatonic behavior at will, but such behavior has a recognized place and receives some degree of approbation in his own culture. The framework of the schizophrenic process remains the same wherever it is found. Where the Tembu, a south African native, regresses in schizophrenia to his own tribal beliefs, the European schizophrenic regresses to what is very likely superstition and primitive folk lore and magic. The Chinese schizophrenic, on the other hand, becomes preoccupied with ideas of possession by animals, gods and devils of magical and extramundane animistic elements still so strong in Chinese culture. There is a large literature on the nature of schizophrenic thought processes, and the analogy between primitive savage thinking and regressed schizophrenic thinking is often striking. To say this is not necessarily to imply that the savage is diseased; but both he and the schizophrenic do not by and large make use of, or lack, the logic, the concept of causality and the capacity for abstract thought of the normal educated modern man. We must remember that personality is shaped by cultural environment, and in each culture one or more types of personality may be allowed freer and more healthy expression. Too, there are great variations in the opportunities allowed for the satisfaction of fundamental drives. Man is to a great extent pliable and "human nature" is not clear-cut and easily delineated as an entity. It is necessary therefore that we obtain a clearer view of the nature of abnormality, and see how much of it is dependent on cultural standards. The forms of behavior in European and American cultures may be conveniently used for comparison with behavior elsewhere in order to enlarge our understanding of them all, but they are neither the commonest nor the most healthy, and they do not possess the finality that might come, for instance, from basically biological forms.

014 -- _____ -- FORMOSA

Lin, Tsung-Li

Reality and vision: a report on the first Asian seminar on mental health and family life

MCGILL UNIVERSITY REVIEW AND NEWSLETTER (Montreal) 10:19-21 (Apr. 1961)

Presents an abstract of an 85 page booklet summarizing psychiatric developments in the relationship between mental

health and the family life in present-day Asia. People in this area now live in the greatest era of social and cultural and technological change in the span of human history. The impact of accelerated change has contributed to family stability and has created serious psychological and social problems. Though the traditional extended family still prevails, family life in Asia is undergoing a marked transition to the smaller nuclear unit.

Urbanization has also had its impact on mental health in Asia. This seminar also brought out the fact that many Asian countries are already "over-urbanized," and cities are becoming increasingly alienated from rural areas. Those villagers who are introduced into cities by relatives or friends and who are unable to adjust to this form of urbanization are most likely to show increasing signs of mental ill health. One good feature about this urbanization is that rapid socio-cultural change provides excellent opportunities for serial studies, within a short span of time of the relationship of human behavior to changing social and environmental factors. Dense populations permit large samplings within small geographic areas.

Unfortunately, attitudes toward research are not favorable in many countries. Governments frequently are so occupied with the day-to-day struggle for socio-economic survival that they should search for solutions to mental health problems by expedient measures instead of research. The acute shortage of mental health personnel confronted by excessive educational demands leaves little time and few resources for research.

The proceedings of this seminar which was held under the joint auspices of the Family Workshop of the Philippines; the Philippine Mental Health Association; the Asia Foundation; the World Federation of Mental Health and the World Health Organization.

015 --

Rin, Hsien; Heu, Chen-chin; and Lie^u, Sau Lien
The characteristics of paranoid reaction in present day Taiwan
McGILL UNIVERSITY REVIEW AND NEWSLETTER (Montreal) 9:29-31
(Dec. 1960)

Cites that a majority of the population of Taiwan is composed of native-born descendents of Chinese emigrants. The mainland Chinese started emigration to Taiwan shortly after World War II. Too, a massive movement of immigration occurred

in 1949-50 with the displacement of the Nationalist government. Factors inherent in migration are of a stressful nature, such as the break-up of families, and economic hardships. Owing to the characteristics of the Chinese family structure, the oldest or the only son is particularly apt to develop mental disorders. The high valuation and overprotection of boys in Chinese families predispose them to schizophrenia. The clinical picture of paranoid reactions was much milder than that of schizophrenia (paranoid type). In the former there was less repression and disintegration of personality. Consequently, the prognosis of paranoid states is better than that of paranoid schizophrenia.

016 --

Shantou, Sung

Oriental medicine and schizophrenia (Taiwan, China)

REPORT OF THE SECOND INTERNATIONAL CONGRESS FOR PSYCHIATRY
3:8-16 (Sept. 1-7, 1957)

Points out that in Oriental countries, especially in China, a special kind of medicine, so-called Chinese Medicine, has developed in the last 4,000 years: moxa therapy, needle puncture, and a special technique of massage are still prevalent there and also in Japan. All of these modes of therapy have their good points, but doctors trained in European ways do not wish to study them further despite the need for such research. Realizing this situation, the author picked upon some Chinese medicines which have long been believed to cure psychoses and studied them carefully and scientifically. Two of these are Yoketsu-Anishinto and Soshinto, both being produced in Japan. They are each packed in 5 gram quantities. Before use, 2 or 3 of these are dissolved in 300 cc. of water and then boiled down to 100 cc.

According to the author, these formulations contain *Cyperus rotundus* L., *Cnidium officinale* Makins, *Pachyma Haelen* Rumpf and other components which have a direct effect on schizophrenia. These drugs remove stupor, improve drowsiness, and produce a livelier expression. The sedative effect of these plants appears slowly but is striking in some cases. Whereas *Cyperus rotundus* L. is responsible for their exciting and *Cnidium officinale* Makins for their sedative effect, *Pachyma Haelen* Rumpf has probably no influence on the psychotic state but only on the blood circulation. Dr. Shansou is convinced that he will find a new method for the treatment of schizophrenia by further research in this field.

017 -- _____ and HONG KONG

Wittkower, E. D. and Freid, J.

Some problems of transcultural psychiatry

INTERNATIONAL JOURNAL OF SOCIAL PSYCHIATRY 3:245-52 (#4--1958)

Presents certain observational relationships between psychiatric states and sociocultural milieu. Data for this paper were gathered from answers to a questionnaire concerning the nature and frequency of mental illness in certain geographical areas. Inquiries were sent to psychiatrists and social scientists in 35 countries in Africa, South America and Asia. Cross-cultural comparisons were most difficult since the nosology and terminology in these countries were so vastly different. None the less, these answers do suggest significant cultural variations in the incidence and symptomatology of mental illness. For instance, it is pointed out that in Indian mental hospitals there is a high frequency of nutritional disturbances while Hong Kong and Formosa report low incidence for the senile psychoses. Schizophrenics are more quiet and less aggressive in primitive cultures as contrasted with the West. On the other hand, manic depressive psychoses are rare in technologically backward areas. By and large, these differences are apparently related to differences in the amount of aggression, guilt and anxiety. Other important factors in the etiology of mental illness are the stresses related to rapid shifts in values within the culture especially in connection with the disruption of solidarity of the family and migrations to new socio-cultural environments.

018 -- EAST AFRICA

Simons, H. J.

Mental disease in Africans: racial determinism

JOURNAL OF MENTAL SCIENCE 104:377-88 (Apr. 1958)

Calls attention to a group of medical psychologists who in the past 30 years have set out to determine East African thought processes, personality traits and mental disorders in terms of racially genetic and cultural disposition. A correlation is assumed or suggested between a specific brain structure, social behavior, psychology and psychopathology. This group's hypotheses can be said to have originated in measurements of the African brain. This organ is said to be smaller, simpler, and hence likely to be inferior in reasoning power and other significant functions as compared with the European brain. As seen by most white observers, the African is described as conventional, highly dependent on physical and emotional stimulation, lacking in spontaneity, foresight, tenacity, judgment,

and humility; inapt for sound abstraction and logic, given to fantasy and fabrication; and in general, as unstable, impulsive, unreliable, irresponsible, and living in the present without reflection or ambition or regard for the rights of people outside his own circle. In the present paper the author refutes all of these statements.

The speculations of the East African Medical School are used to provide a theory of African mental disorders. These are described in conventional Krapelinian terms; their incidence is assessed largely by an examination of admissions to mental hospitals; and these are compared with mental disorders in Europeans and at times with American Negroes. Schizophrenia is the most common psychiatric disorder, but its recorded incidence is far lower than in Europeans. This is the picture drawn by the East African Medical School on admittedly scanty information. As presented, it reveals a people far freer than Europeans from most if not all kinds of mental ailment.

There is a great difference in conception of African mental illness from the European type. Methods of treatment also differ in the two societies. Facilities for modern types of treatment are not available for the greater number of Africans, who by approved European standards need psychiatric therapy. The approach to the illness which in African terminology is known as thwasa, illustrates the difference in conception and treatment. The verb ukuthwasa means in Zulu and Xhosa to come out, renew -- as said of the new moon or start of a season, and also to initiate tribesmen into the mysteries of divination from such process he is said to emerge a new being. Thwasa also describes a state, a condition marked by pains in the limbs, and "all over" the body, nausea, anorexia, hallucinations, wild talk, nervousness, and excitability. Dreams figure largely in the symptoms of thwasa. The indicated course of thwasa treatment lasts about one year, in which time the patient experiences a dream or series of dreams which sets a pattern involving such objects as cattle, snakes, birds, stones and spears. These objects are symbolically interpreted as communications from the ancestral spirits, a "calling." Certain aspects of tribal society as compared to European psychiatric practice reveal that the thwasa patient just prior to being "called," resembled a catatonic phase in schizophrenia.

In Africa the non-European mental hospital population comprises a highly selected group. The African section particularly rarely includes cases of senile dementia, uncomplicated mental defect, alcoholic dementia, paranoia, or schizophrenia simplex. In comparison with European mental patients for whom accommodation is usually available, the proportion of

African schizophrenics is high. This has led some observers to assume that there is a significant racial difference in the pattern of mental disorders. It seems, however, that the difference is due not to an African or European idiosyncrasy but to social and administrative policies.

019 -- _____ -- KENYA

Carothers, J. C.

The African mind in health and disease

WHO MONOGRAPH SERIES 17:139-40 (1953)

Deals with all of the standard forms of schizophrenia: paranoid, paraphrenic, and paranoiac types are included except when distinctions are explicit.

Schizophrenia is par excellence the chronic form of insanity in Africans as in Europeans -- a fact reflected in all figures concerning inmates of African mental hospitals. Thirty of 87 patients (35.7%) of the mental hospital at Zomba were diagnosed as schizophrenic, and in South Africa on December 31, 1950, no less than 5,255 patients (67.5%) among 7,782 mentally disordered in-patients were suffering from various forms of schizophrenia. Dr. Carothers saw 185 (30.4%) among 609 total admissions in Kenya, and the comparable figure in South Africa for 1950 was 635 (52.3%) among 1,215 patients.

Many points arise for discussion in regard to schizophrenia. Although schizophrenia in Africans does appear in the familiar European patterns, a large proportion of the cases are amorphous. Paranoia is relatively rare. Regarding this type of schizophrenia, the author says: "It was shown that paranoia is relatively uncommon (in Africans). When it did occur, it was almost invariably related to unusual environmental conditions. A further fact was brought out in regard to the paranoid type of schizophrenia: In a previous article the author concluded that it was impossible to judge the degree of education of an African in any exact or scientific manner. This conclusion still holds, but as a rough and ready substitute, the African interpreter at the hospital was requested to prepare a list of all those in-patients whom he considered to be fairly well educated along European lines....All patients diagnosed as schizophrenic or paranoiac were independently classified into two groups -- (a) those with a tendency to chronic delusions (persecutory or grandiose) and usually a good preservation of the personality, and (b) those with no such tendency and usually a marked disintegration of the personality....Group (a) includes those with a simple, hebe-

(EAST AFRICA -- contd.)

phrenic, and catatonic schizophrenia. It was then found that among 119 non-educated cases only 15 (13%) were paranoid in type, whereas among 30 educated cases there were also 15 paranoid patients (50%). The difference is significant in a high degree, with a chi-square figure of 21. Hence, there seems to be no reason to doubt that paranoid types of schizophrenia rarely occur in Africans, unless they have received some type of "European education" or "a type of sophistication that is its equivalent."

020 -- _____ -- UGANDA

Tewfik, G. I.

Psychoses in Africa

McGILL UNIVERSITY REVIEW AND NEWSLETTER (Montreal, P.Q.)

10:43-45 (Apr. 1961)

Discusses a 15 page mimeographed paper which was presented by the author at a CCTA/CSA/WFMH/WHO Specialists Meeting on Mental Health held at Bukavu, March 10-18, 1958. In this paper certain aspects of African psychoses are discussed as seen by the author in Uganda. Tewfik does not restrict himself to schizophrenia, but he makes some remarks which are relevant to the problem of schizophrenia in Africa.

In a series of diagnoses embracing 304 patients admitted over a six-month period to Mulago Mental Hospital, but one case was diagnosed as schizophrenic and 247 remained undiagnosed. With these figures, the author feels that it would be very difficult to give an incidence of schizophrenia. He also feels that this condition is very grossly estimated in African studies. Dr. Tewfik is of the opinion that schizophrenia is a condition which cannot be diagnosed until at least nine months have elapsed from the onset of the illness.

021 -- GERMANY

Redlich, Fritz C.

Klassenzugehörigkeit Kultur un Schizophrenie

Class membership, culture and schizophrenia

PSYCHE (Heidelberg) 12:401-07 (1958)

Cites that although investigators are still in the dark concerning the role of social and cultural variables in the etiology of schizophrenia, our knowledge of social factors affecting treatment has become more precise and of practical importance.

Rassidakis, N.

Findings regarding the distribution of the psychiatric spectrum in the various geographical regions of Greece

McGILL UNIVERSITY REVIEW AND NEWSLETTER (Montreal, P.Q.)

7:50-52 (Jan. 1960)

Provides a differential diagnoses for 1,807 cases of mental illness from 8 nosological entities from 12 geographic regions. These cases concern hospitalized patients from all over the country admitted to mental asylums during the past 15 years. The preponderance of diagnoses directed toward schizophrenia is reflected by the fact that almost half of the cases in the series analyzed were schizophrenic. Too, it was noted that in the north (Macedonia and Thrace) the incidence of schizophrenia was much greater than in the south (Crete, the Dodecanese Islands and the Peloponnese). The ratio between affective disorders and schizophrenia seems to be considerably lower in the North than in the South. The incidence according to nosological classification are percentage-wise:

MENTAL DISORDERS	%
SCHIZOPHRENIA	51.9
Manic-Depressive Psychoses	9.9
Involutional Melancholia	3.6
Paranoid Psychoses	3.7
Pre- and Senile Psychoses	7.7
General Paresis of Insane	1.4
Alcoholic Psychoses	3.7
Psychopathic Personalities	2.9
Mental Defectiveness	5.9
Psychoneuroses	4.8
Epilepsies	2.6
Schizo-affective disorders	0.4
Unclassified Psychoses	1.5

Despinoy, M.; Benoist, A. and Mares, J.
Schizophrenia in Martinique (Haiti)
 MCGILL UNIVERSITY REVIEW AND NEWSLETTER (Montreal, P.Q.)
 9:37-39 (Dec. 1960)

Presents a study of 368 schizophrenic patients admitted to the Mental Hospital of Martinique since 1953. The authors first state their diagnostic criteria. Patients were classified in terms of the four main sub-forms of schizophrenia. In Martinique, African cultural vestiges are few although the population is 95% colored. In a consideration of the morbidity rate of schizophrenia, 73 cases from a population of 240,000 are detected annually. The mean age of the schizophrenic is 33. The life expectancy is 55. An estimation based on thorough calculations places the total number of schizophrenics in Martinique as 1,600, which amounts to a morbidity rate of 0.66%. This compares to a morbidity schizophrenic rate of 0.85 for Europe. (As regards symptom peculiarities, the only marked characteristic feature as compared to European schizophrenics is the predominance of magical and/or mystical delusional themes.) Rorschach tests confirm the basic similarity of the schizophrenic psychopathological structure in Martinique with that found in Europe. Hence, the incidence and nature of schizophrenia seem, to a large extent, to be unrelated special culture and racial factors in Martinique.

Mars, Louis
La Schizophrenie en Haiti
Schizophrenia in Haiti
 MCGILL UNIVERSITY REVIEW AND NEWSLETTER 9:39-40 (Dec. 1960)

Contentends that mental illness is much more frequent in Haiti than is generally assumed. The run-of-the-mine of patients are not seen by a psychiatrist. In fact, considering the general poverty of the Haitian population, it is surprising that there isn't more crime, suicides and mental illness. This paradox is explained by the fact that powerful ways of emotional relief are provided by popular religion (Voodoo), by official religion (Catholicism) and other cultural forces.

Dr. Mars gives a number of case histories. He emphasizes that by and large the basic features of schizophrenia are the same in Haiti as in other countries. The cultural setting is often reflected in the disease, although in a fragmentary and distorted way. One or the other cultural feature is disconnected

from its context and utilized in the delusional system of the patient. For instance, a woman patient had delusions of persecution and believed that there was a plot against her. She knew it because she received information about it from her personal "loa," a Voodoo diety (which apparently played the role of a guardian spirit). In another instance, we see how the process of schizophrenic dissociation is expressed in a mixture of creole, the everyday Haitian speech, and French, the official and administrative language, as spoken by the patient.

Still more interesting is the frequent occurrence of acute paranoid reactions. An individual is under the stress of growing difficulties and repeated failures; he becomes suspicious, hostile; he feels persecuted; he begins to irritate and accuse other people in turn. In Western civilization, this individual would be considered mentally ill and sent to a psychiatrist. The situation in Haiti is quite different. A kind of spontaneous collective psychotherapy takes place. People listen with a sympathetic attention to the patient and start to look for a job for him, even for a well-paid one in accordance with his capacities. Gradually the projections recede and the individual is reintegrated into the community. Should this means fail, there remains another drastic one: a diviner is consulted and designates an alleged responsible individual who is now treated by the patient as a scapegoat.

This abstract was first published in the Review and Newsletter (Dec. 1960) and presents a summary of a 21 page article which originally appeared in the Bulletin du Bureau d'Ethnologie, Haiti #15 (Mar. 1958).

025 -- HAWAII -- MULTICULTURAL

Finney, J. C.

Psychiatry and multiculturalism in Hawaii

THIRD WORLD CONFERENCE OF PSYCHIATRY (ABSTRACTS) 1:188-89
(June 4-10, 1961)

States that in spite of acculturation, some psychological differences persist among Hawaii's ethnic groups (European-American, Polynesian, Japanese, Chinese, Filipino).

In a program for short-term psychiatric in-patient treatment in a general hospital, one small group, the Portuguese, made up a very large portion. This resulted from the incidence of one diagnostic condition (hysterical-suicide attempts) in women.

Japanese and Filipinos in a mental hospital with the same diagnosis, paranoid schizophrenia, had quite different symptoms and signs, the Japanese reacting more quietly and intrapunitively, and the Filipinos having more outwardly expressive symptoms.

Interviews on racial attitudes showed defenses such as projection, reaction-formation, and repression. In some cases, perceptions and attitudes about ethnic groups showed three layers, each a defense against a deeper-lying attitude or perception.

026 --

Kimmich, Robert A.
Ethnic aspects of schizophrenia in Hawaii
PSYCHIATRY 23:97-102 (Feb. 1960)

Calls attention to the unique geographical and sociological position of Hawaii. Located in the central Pacific Ocean, 2,300 miles from land, it has a population of one-half a million people located in a relatively stable cultural environment composed of several quite different ethnic groups. Here indeed East meets West. As parts of the United States all groups operate in the same general frame of reference -- namely, that of an English-speaking modern American community. By and large, each ethnic group retains its own identity and sub-culture. Because of its relatively isolated position, in and out migration of the civilian population has until quite recently been gradual and comparatively small. Hawaii, therefore, is potentially a remarkable sociological laboratory.

Since the Territorial Hospital is the only psychiatric hospital in Hawaii, it follows that research on the subject embraces practically all the patients who were hospitalized for schizophrenia in the Territory during the 10 years ending June 30, 1956. The following table gives the official 1950 United States census figures to derive the average annual first admission rates according to cultural group and sub-group. A further breakdown gives population percentage and rate per 100,000 of psychotic and schizophrenic first admissions:

PERCENTAGE AND RATE OF PSYCHOTIC AND
SCHIZOPHRENIC FIRST ADMISSIONS

	<u>1950 Popu- lation*</u>		<u>Total First Admissions</u>		<u>Psychotic First Admissions</u>		<u>Schizo- phrenic First Admissions</u>	
	<u>Per- cent</u>	<u>Count</u>	<u>Per- cent</u>	<u>Rate</u>	<u>Per- cent</u>	<u>Rate</u>	<u>Per- cent</u>	<u>Rate</u>
Japanese	40	128,615	26	72	30	62	36	37
Caucasian	21	68,213	28	144	22	87	17	34
Filipino	14	43,202	18	151	22	135	25	77
Part Hawaiian	11	36,132	10	94	8	56	8	30
Chinese	7	22,828	5	78	5	61	5	30
Hawaiian	3	9,189	5	177	5	144	3	44
Other Races	4	12,609	8	215	8	154	6	62
All Races	100	320,788	100	109	100	82	100	42

*Civilian population 15 years and over.

With the above statistics in mind, it might be interesting to compare a few of the personality differences and similarities of Hawaii's various ethnic groups: The Japanese are generally quiet, hard-working, and certainly carefully self-controlled. The Chinese and to some extent the Koreans, are more outgoing, more aggressive and more expressive. The Caucasians are comparatively aggressive and frank, relatively outgoing, and variable in their social behavior. The Part Hawaiians vary greatly depending upon what the family mixture happens to be. Some Part Hawaiians and the Caucasian Hawaiians tend to be pleasant, easy-going and expressive. The Hawaiians retain a sophistication that is most refreshing. They are not particularly aggressive, but are emotional, and react quickly to real or fancied rejection. Their reaction to authority is strongly ambivalent, similar to that seen in older children. There is a tendency toward solving conflicts by acting-out. The Filipino is usually expressive and can be impulsive. He takes great pride in his reputation.

Upon examination of the above table, it can be seen that the Japanese have the lowest "Total First Admissions rate" (72) to the hospital. At the same time, the Caucasian, Hawaiian, Filipino and Other Races categories have admission rates considerably above the All Races figure. There are a multitudinous number of factors involved in any explaining of the reasons for admission to a hospital that

generalizations only can be made. The Orientals tend to their mentally ill and care for them at home, although mental illness is a matter of shame in most families. Oriental people who should be hospitalized are simply not brought to the hospital. On the other hand, these figures may be an accurate reflection of a lower psychiatric morbidity rate. Other variables with regard to first admissions are also given. One of these variables concerns the Caucasian and Part Hawaiian ethnic groups, who may show a low family or neighborhood tolerance for mental disorders. For this reason there are a greater number of persons who are hospitalized for psychiatric reasons.

Increasing intermarriage, the impact of statehood and better transportation will no doubt change the ethnic picture in Hawaii. The author states that it is hoped that intensive multidisciplinary research can be done in Hawaii relevant to the effect of culture on personality before another generation changes the ethnic situation so greatly that any fruitful ethnological data will be lost.

027 -- INDIA

Bhaskaran, K.

A psychiatric study of schizophrenic reaction patterns in an Indian mental hospital

INTERNATIONAL JOURNAL OF SOCIAL PSYCHIATRY 5:41 (Jan. 1959)

Attempts to clarify the role of cultural factors in the incidence and symptomatology of schizophrenia in India. By and large, patients were drawn from the mental hospital at Ranchi, Bihar State, India. The patients were predominantly from Northern, Eastern, and Central India, with some 65% coming from the state of Bengal. They were for the most part drawn from urban or semi-urban areas, from upper- or lower-middle class families and were almost all Hindus. European education has a profound affect on the thought and action of these people. However, the joint family structure still persists and marriage is effected through parental arrangement. Respect for parents and other figures is highly extolled. Masturbation is forbidden and interest in sexual matters is disapproved. Sexual intermingling of younger persons is banned. In marriage the wife is given consideration as a mother but little respect as a wife. In general, the widow's fare is especially unwholesome.

The present paper is based on a series of 138 first admission schizophrenics (89 males -- 49 females). Most

of these cases were detected in persons 20-29 years of age in both sexes. More males than females were unmarried. Catatonic excitement stupor, unclassified schizophrenia and simple schizophrenia affected the younger age group, while the paranoid type involved patients over 35. Among the first symptoms to appear (as related by relatives) in order of frequency, are: irrelevant talk, depressive spells, apathy toward surroundings, feelings of persecution, social withdrawal, lack of initiative, wandering tendency, irritability, restlessness, vague apprehension, hypochondriacal complaints, sleeplessness and morbid suspiciousness. All the sub-types of schizophrenia were seen in both sexes. An analysis of the unclassified type (manifesting a variety of symptoms such as hallucinations, poorly systematized delusional ideas, inappropriate affect) in both sexes showed such manifestations as dullness, apathy, depression, and lack of interest in surroundings.

Among the precipitating and psychodynamic factors in such cases of schizophrenia, catatonic excitement and stupor cases were frequently seen. Some of these factors include such disappointments as failures in examinations, stress associated with various enterprises, the death of a near relative and marriage. In women, child birth, abortion, desertion, or non-acceptance by the husband were especially noticeable factors. In the younger male subjects, masturbation was a contributing factor, leading to other florid schizophrenic elaborations, such as ideas of reference, auditory hallucinations, and hypochondriacal preoccupations, usually involving the genitals. The cultural emphasis on the power of will, religious meditation and continence very often accentuate conflicts and tension associated with masturbation. This led to guilt complexes in men associated with sexual inadequacy, and willingness to blame the female partner for this impotence.

028 -- _____

Gaitonda, M. R.

Psychiatry in India

PROGRESS IN PSYCHOTHERAPY 4:289-95 (1959)

Attempts to correlate mental illness in India with certain cultural factors. He feels that the joint family structure, prolonged breast feeding, great respect shown for age and parental authority give individual emotional security. At the same time, it also endows the super-ego with a distinct social characteristic rather than a personal one. Family religion and social organization promote a

(INDIA -- contd.)

basic personality pattern which emphasizes conformity, a sense of dependence and self-respect and minimizes opportunities for frustration and acute anxiety.

Because Indian culture does not idolize youth, and growing old is not considered a tragedy, geriatric problems are not so acute as in the Western world. The incidence of juvenile delinquency is remarkably low, homosexuality is not a psychological problem, and alcoholism is very rare. By and large, psychiatric disturbances are for the most part associated with nutritional deficiencies and cannabis indica intoxication. Due to the Indian outlook on life, diagnosis of borderline schizophrenia is rarely made.

Certain typically Indian institutions such as the "Ashram" are able to care for the psychological needs and problems in many people.

029 -- _____

Godinwaswamy, M. V.

Some problems of mental ailments in India

JOURNAL OF THE ALL-INDIA INSTITUTE OF MENTAL HEALTH

1:1-6 (July 1958)

Discusses, along with a number of other cultural considerations, familial relationships as they are found in Indian society. Apparently these relationships are very intense. Brothers accept without question the responsibility for widowed or unmarried sisters. Often the presence of an unmarried sister creates dissention and unpleasant domestic friction among newly-weds. The elders of the family are held in great veneration. Consequently, isolation of the aged is rare. In India, the life expectancy is short which may in part account for the lesser amount of mental illness as compared with the same situation in the West. The care of the aged is not much of a problem in villages. However, it is becoming an ever-increasing serious problem in the larger cities because of restricted accommodations and a competitive way of life. In agricultural communities, the male head of the family is losing his authoritarian position: The unity of the joint-family is broken by migrations of the sons to cities. Decreasing interest in farming and agriculture has also led to a breakdown of these close ties.

As the culture changes its values, simple religious ideas and beliefs and intense family loyalties are gradually disappearing, and are being replaced by what the

author calls the tyrannies of modern existence: Tyranny of Mediocrity, tyranny of Time, tyranny of the Commonplace Affection, tyranny of the Spoken and Written Word (Slogans) and tyranny of Caste (in the South). Emancipation of women is another of the changes responsible for a great deal of neuroses and restlessness among the young men and women of the community.

030 -- _____

Hoch, Erna M.

Psychiatrie in Indien

Psychiatry in India

PRAXIS (Bern, Schweiz) 46:1145-50 (Dec. 1957)

Comments on the Indian "joint family" as a factor of psychiatric relevance. This type of family life in which Indian children grow up does not further the emotional differentiation of individuals and endows them with a lasting need for security. Boys and girls marry at an early age while still immature. For a young woman motherhood is a duty and a question of prestige; her personal and social value is low if she is sterile or if she does not produce males. The Indian national character has been molded by centuries of oppression, beginning with the Mohammedan conquest in the 12th century. For the common man in India, life is unbelievably hard. He feels helpless in a world of mysterious and inscrutable powers. Today's modern industrialization is under-mining the security provided by the "joint family" and the "caste" system, without providing the security which could result from a higher economical level and better administration.

The state of Uttar Pradesh, from which this article emanates, has 64 million inhabitants but approximately only 1,000 beds for mental patients. In the medical schools, the teaching of psychiatry is almost non-existent. Many cases of schizophrenia and of depression with refusal to eat are misunderstood to be the devout accomplishment of religious convictions. The joint family system makes it possible to keep patients at home, even severe psychotics, for a prolonged period of time. Many mental patients are taken care of by distant relatives, or even kept in inns or public places.

In India, more often than in Europe, organic illness, notably syphilis and encephalitis, are often misdiagnosed

as schizophrenia. On the other hand, the clinical picture of melancholia is exactly the same as in Western countries. In regard to schizophrenia -- a very frequent condition -- affective contact is better maintained than in Europe. Too, more often than in Europe, schizophrenia is restricted to the "primary symptoms" or colored by hysterical manifestations.

031 -- _____

Hoch, Erna M.

Psychiatrische beobachtungen und Erfahrungen an Indischen Patienten

Psychiatric observations and experiences with Indian patients

PRAXIS (Bern, Schweiz) 48:1051-57 (Nov. 1951)

Points out that the Westernized type of Indian is more apt to seek psychiatric help spontaneously than the disturbed person in a village community. Social structures such as the joint family, the village community, and the caste system are extremely difficult for the individualistic Western minds to comprehend. Symptoms of neurosis and psychosis are much less definite than in the West. Indian schizophrenics do not show that "lack of emotional contact" which Western psychiatrists consider as a part of the disease. The author suspects that the true reason for that difference lies in the rejecting, debasing, repelling attitude of the environment toward the schizophrenic in the Western world, and the social stigma attached to this illness. In India, the prestige of adulthood, of efficiency, of economic utility, is not so high. Certain adults do not feel ashamed to confess that they would prefer to be children. One particular serious problem is that of the overburdening of the youth with a heavy and rigid system of examinations. The period of examination is also that of an increase in frequency of depression and schizophrenia and of suicide in young people.

032 -- _____

Kohlmeyer, W. A. and Fernandes, X.

Psychiatry in India: family approach in the treatment of mental disorders

THIRD WORLD CONGRESS OF PSYCHIATRY (ABSTRACTS) 1:338-39
(June 4-10, 1961)

Compares India where there is a remarkable paucity of inpatient facilities with Western countries where this

scarcity does not exist. This is possible, primarily, because of a more tolerant attitude toward the mentally deranged; the same degree of segregation is not demanded. The traditional joint family system still provides substantial emotional and material support for the mental patient. The family undertakes the responsibility which has fallen to the State in most other cultures. Because of religious belief or superstition the family may try faith healing and indigenous medicine before bringing the patient for modern psychiatric treatment. The latter is often insufficient and inadequate because of poor facilities. Ultimately the patient will become the ward of the family once again.

The Mental Health Centre of the Christian Medical College, Vellore, was designed as a project to utilize the desirable feature of the joint family system. Its location and construction were chosen to be easily accessible, and in no way forbidding, to the village patient. It has been established as a firm policy that one or more of the relatives must remain throughout treatment, taking responsibility for the safety and general care of the patient. They are provided with a small living unit consisting of room, bath and kitchen, so that the mode of living does not change greatly when the patient is hospitalized.

The relatives are informed of each step in the treatment, and every opportunity is taken to explain to them not only the illness of the patient, but general rules of mental health. There are in-patient facilities for only 18 patients, but an average of 60 new patients are examined each month. Those who cannot be admitted are treated as day patients with the same facilities as the in-patients.

An evaluation of the results of this project over an 18 month period demonstrates that the family participation during treatment establishes more satisfactory conditions for lasting rehabilitation.

With this family approach it is possible to reach a large number of patients with minimum staff and facilities. This project could serve as a prototype for the future planning of small active treatment units widely distributed throughout the country. Thus the undesirable features of custodial care in large hospitals would be avoided.

033 -- _____ and ENGLAND

Mayer-Gross, W.

The chronic mental patient in India and in England

LANCET 7033:1265-67 (June 14, 1958)

Gives a number of statistics which serve to compare the chronic mental patient in India and his counterpart in England. The Bangalore Hospital is the only psychiatric hospital in Mysore State and serves a population of approximately 2 million. In the hope of throwing some light on the universal problem of chronic mental patients, a survey of the chronic mental cases in this hospital was made, using a method previously employed in a British mental hospital. Life tables for India (U.N. -- 1954) show the life-expectancy of the Indian at birth to be 32 years. Even at the age of 25 he has only a further 30 years. Thus not only does the Indian chronic mental patient have a much shorter span of life than his English brother because of communicable and nutritional disorders, but also the low life-expectation of the general population makes the total risk of mental breakdown far less. However, as communicable and other diseases are brought under control in India, the life-expectancy will rise rapidly and concomitantly there will be an increase in the incidence of mental disorder. Not only will there be an increase of admissions to mental hospitals, but also existing patients will live longer and become chronic. It is noted that modern treatment of ailments has not obviously prevented chronicity, especially in schizophrenes.

Though one should be cautious in comparing diagnostic groups of Indian and English patients, schizophrenics occur in roughly the same proportion in both groups. The vastly different social and cultural background from which the two groups are drawn, despite certain similarities, suggests that there should be a vast difference in the development of schizophrenia. This, however, is not true and any differences that do exist may well have been determined by environment.

034 -- INDONESIA

Santoso, Slamet Iman

Social background for psychotherapy in Indonesia

McGILL UNIVERSITY REVIEW AND NEWSLETTER (Montreal)

7:22-24 (Jan. 1960)

Cites the awareness of the author for the need of applying sociological and anthropological knowledge and

insights to the understanding of the forces that make for mental health in modern Indonesia. Here, due to the lack of proper medical facilities, organic diseases have been given therapy priority over mental illness. Family life in Indonesia is today most profoundly disrupted due to the "emancipation of women." The traditional dominance of the father is now shaken, but new effective patterns of a democratic family-type have not clearly emerged. Dr. Santoso points out that in his country, the psychotherapist duty is not only to treat the individual patients, but also to think in the direction of betterment and social development in the widest sense.

It is most interesting to note that there are only nine qualified psychiatrists in all of Indonesia (population 80,000,000).

035 -- IRELAND AND ITALY

Fantl, Berta and Schiro, Joseph
Culture variables in the behavior patterns and symptom formation of 15 Irish and 15 Italian female schizophrenics
MCGILL UNIVERSITY REVIEW AND NEWSLETTER (Montreal, P.Q.)
9:46-47 (Dec. 1960)

Presents an abstract of a paper on the above subject first published in the International Journal of Social Psychiatry 4:245-53 (Spring 1959). The object of this study was to compare Italian and Irish schizophrenic patients. Two groups of 15 patients each (all females), as homogeneous as possible, were drawn from the files of the New York State Psychiatric Institute. Data thus obtained were compared with those of Opler in his similar study of male schizophrenics of the same two sub-cultures. In contrast to Opler's findings, a large proportion of overt homosexuals was found in both the Italian and the Irish female group. The rate of alcoholism on the other hand was comparatively low in female Irish patients but higher than that of female Italian patients. As in Opler's study, the incidence of impulsiveness, of unruly behavior, and of difficulties with authority figures was more pronounced in the Italian group, and the incidence of guilt over sexuality much higher in the Irish group than in the Italian female patients. Almost all the Irish females tested showed delusions and hypochondriacal symptoms, i.e., a much larger proportion than in the Italian female group.

036 --

Singer, Jerome L. and Opler, Marvin
Contrasting patterns of fantasy and motility in Italian
and Irish schizophrenics

JOURNAL OF ABNORMAL AND SOCIAL PSYCHOLOGY 53:42-47
(Jan.-Mar. 1956)

Calls attention to the development of several hypotheses concerning differences in fantasy and motor activity of schizophrenics of Italian and Irish descent on the basis of anthropological evaluation of cultural patterns and child rearing practices. Schizophrenics of Irish descent were expected to be more given to imaginative behavior and motor control when compared with those of Italian descent. Psychological instruments used were the Rorschach, Barron's Movement-Threshold Inkblots, TAT, Porteus Mazes, tests of time estimation, motor inhibition, admission denial of frustration, and ward behavior ratings. Sixty male veteran patients were used as subjects, one-half each of Irish and Italian descent. The results appeared to support the hypothesis of persistent difference in motor and fantasy activity. Implications for review of psychiatric nosology, personality research and interdisciplinary collaboration were suggested.

037 -- ISRAEL -- ORIENTAL-JEWISH IMMIGRANTS

Hes, J. Ph.

Hypochondriasis in Oriental-Jewish immigrants (Israel)

INTERNATIONAL JOURNAL OF SOCIAL PSYCHIATRY 4:18-23
(Summer 1958)

Attempts to discover whether hypochondriasis occurs more frequently among Oriental-Jewish immigrants in Israel than in Occidental (European) immigrants and whether the incidence is related to schizophrenia. The author compares 124 run-of-the-mine cases of Oriental patients hospitalized during the years 1952-54 with the same number of non-orientals with similar age and sex features. The patients designated "Oriental" find their origin in the following countries: Iraq, 34; North Africa, 48; Yemen, 20; Aden, Afghanistan, Persia and Syria, 22. The "Occidental" group was divided into: West-Europeans, 27, Central Europeans, 12; Balkans, 12; Rumanians, 25; Eastern Europeans (Poland, Lithuania and Russia), 50.

A further breakdown shows that of the 34 Iraqis, 17 were hypochondriacs, 12 schizophrenics and 5 non-

schizophrenics. Of the 48 North Africans, 11 were hypochondriacs and 6 schizophrenics. Of the 20 Yemenites, 4 were hypochondriacs, and 2 schizophrenics. Of the remaining 22, 8 were hypochondriacs, half of which were schizophrenics. In the Occidental patients, the results were as follows: Of the 12 Central European subjects, 2 of them were hypochondriacs; 1 schizophrenic. The Balkan patients were negative for both conditions. Of the 25 Rumanians, 3 were hypochondriacs; no schizophrenics. Finally, of the 50 East-Europeans, 5 patients were hypochondriacs, 3 of whom were schizophrenic.

Hence, 40 out of 124 Oriental patients showed hypochondriacal complaints, 24 of whom were schizophrenic, whereas only 11 of the same number of Occidental patients were hypochondriacal and 4 of this number schizophrenic. To recapitulate, a greater incidence of hypochondriasis was found in Oriental-Jewish immigrants as compared with a matched Occidental group; both groups being patients in a mental hospital. The author is of the opinion that Oriental patients may manifest schizophrenia in the guise of hypochondriasis more often than do Occidental patients.

038 -- ITALY

Parsons, Anne

A schizophrenic episode in a Neopolitan slum

PSYCHIATRY 24:109-21 (May 1961)

Cites a few case histories of schizophrenics published over the past ten years in which patients originate in cultural settings quite different from those which provide the clientele of psychodynamic psychiatry. By and large, the cross-cultural comparison of clinical material from varied cultural environments should provide a useful research method for psychiatry, in that systematic variation of socio-cultural factors may provide a laboratory setting. In the present paper the author gives a case history of a young woman hospitalized in the Provincial Hospital of Naples. Two working hypotheses serve as guidelines for her presentation: (1) that the patient has a schizophrenic episode in that she manifests symptoms and dynamic patterns which are common to other schizophrenics, and (2) that there are certain respects in which this patient does not fit the "typical" patterns of the schizophrenic personality but has distinctive features which can best be understood by reference to the particular

(ITALY -- contd.)

setting in which it took place. In this case the setting was a one-room basso, a ground floor dwelling which is typical of Neapolitan slums; when the door is left open the entire family living accommodations can be viewed from the street.

The design of the first hypothesis based on case selection of patients is to determine whether these cases could be diagnosed as schizophrenic according to American usage. Hence it was necessary to assimilate several specific terms in current Italian usage as being equivalent to the broader category of schizophrenia as used in the United States. Although many similarities to American schizophrenics can be pointed out, one can also examine the patient in her cultural context in such a way as to isolate ways in which her personality and behavior differ from others in the same milieu.

039 -- _____

Parsons, Anne

Family dynamics in South Italian schizophrenics

ARCHIVES OF GENERAL PSYCHIATRY 3:507-17 (Nov. 1960)

Calls attention to a number of recent studies which indicate that a closer analysis of the associated family dynamics may make an important contribution to the understanding of schizophrenia. As regards studies of the families of schizophrenics, Dr. Parsons is of the opinion that the comparative approach may help to eliminate biases which the observer may see intrafamilial behavior in such a light as to allow for the establishment of general formulations. In the present paper, she has presented some data concerning schizophrenic women in southern Italy.

Studies carried out in the U.S. indicate that there may be variations in patients coming from different class, economic or ethnic levels, both in the symptoms and personality of the patient and in the associated family patterns. In comparing Italo-American and Irish-American male schizophrenics, it has been shown (Opler and Singer) that the Italians were less prone to elaborate fantasy or delusional development, more likely to act aggressively on the ward, and more likely to have had histories of overt homosexuality. Such homosexuality is related to a freer attitude concerning sexuality and to an acute conflict with a powerful father figure. The writer's observations of Italian-born schizophrenic women in the United States indicate parallel particularities. Contrary to the widespread image of the

schizophrenic as a lonely and isolated person, lacking in any real identity, Italian female patients often appear to have a very deep subjective involvement in the on-going process of family life. Two cases encountered in the U.S. are presented as examples.

The south Italian family appears as a highly centripetal system when it is compared to the middle-class American family. The major social expectations center on loyalty to persons related by birth rather than on independent initiative and achievement. By and large, marriage involves a realignment of family relationships but does not usually sharply interrupt the close tie to the natal family. A mother may expect close involvement with a daughter even after the latter marries. Cousin marriages, although frowned upon by the Catholic church, are often condoned. Hence, it is not surprising that intense dependency is such a prominent feature in the Italian female schizophrenic. The cases studied in Italy were approached with this hypothesis in mind. Furthermore, it was predicted that Dr. Parsons would find very close reciprocal relationships of dependency between patients and their mothers and that psychotic episodes would often occur on the occasion of the latter's death or physical separation.

In order to obtain a better view of family patterns occurring in south Italian schizophrenic women, a series of 25 patients from public hospitals in Naples was investigated. The majority of these patients came from economically marginal groups. Their educational background was very shallow. About half of the sample were acute first admissions and none had a total of more than four years' hospitalization at the time of study. During the course of these observations, 15 of the patients were married. The marriage ceremony had little effect on the continuity of natal ties. One case in point is that of a young Italian girl who married her father's sister's son and was so closely involved with her father as to separate from her husband and return to live with the father in what might have been an incestuous relationship. A second case which was very similar may have also involved overt incest. Both patients were considered extremely jealous and capricious personalities before psychosis. Two other patients closely involved with the mother presented quite different personality types in that both were quiet and dutiful. The mother dependency involvement was effected by the lack of a father figure in the home; one was an illegitimate child brought up

(ITALY -- contd.)

by its mother while the other was an only child left fatherless by his death during the mother's only pregnancy.

The mode of reasoning which Dr. Parsons follows in the present paper is to take a general model of the relevant family structure and isolate points of potential weakness, rather than looking to see whether the predicted breakdowns actually occur among schizophrenic patients. She believes that comparative analysis of family structure could be very profitably adopted in the study of pathologic family constellations. If it were possible to study schizophrenics in the Trobriand Islands (the classic case of the matrilineal society analyzed by Malinowski) one might look for the breakdown of the elaborate taboos surrounding brother-sister relationships. Thus, it may be that if family determinants of schizophrenia are ever conclusively isolated, they will fall within the range of a violation of taboos such as that on incest within the elementary family which now appears to be a universal form of social structure.

040 -- JAPAN-CANADA -- ISSEI AND NISEI

Terashima, Shogo

Schizophrenic Japanese-Canadians and their socio-cultural backgrounds

CANADIAN PSYCHIATRIC ASSOCIATION JOURNAL (Ottawa, P. O.)
3:53-62 (Apr. 1958)

Relates to the examination of three second-generation Japanese-Canadian schizophrenic patients. In this study, the characteristics of family structure play a paramount role in the developing difficulties. Emphasis on the obligation of the children toward the aging parents, the traditional respect for the parents, and parental arrangement of marriages all conflict with value systems in the new culture. In addition, the unquestioned absolute supremacy of the father and the absolute self-sacrifice of the mother counters existing trends in the surrounding minority groups. Lack of acceptance by the dominant Canadian society on the one hand, and rejection by the Issei, the first generation Japanese-Canadian as not "good" Japanese on the other, forced the Nisei to become a truly marginal group with enforced dependency on their own ethnic community. Schizophrenic withdrawal has been regarded as a defense against overpowering feelings of guilt and anxiety which can be traced back to difficulties in early interpersonal relations, such as those created in these "socially closed" families.

041 -- MAURITIUS -- ILE de FRANCE

Raman, A. C.

The effect of acculturation on mental health
(in Mauritius)

MCGILL UNIVERSITY REVIEW AND NEWSLETTER (Montreal)

10:29-32 (Apr. 1961)

Summarizes an investigation of the process of acculturation and its effects on the inhabitants of Mauritius, and more specifically, describes in detail an extensive field study of a single village, Triolet, where the pace and consequence of culture change have been extraordinary. All groups here are undergoing "Westernization" with the Hindu Indian group taking precedence and with other non-French segments following the "French" cultural leads.

The traditional Hindu family and family life centered in the home and based on loyalty and respect for the father is heavily threatened. Younger generations refuse increasingly to consent to arranged marriages and defiance to the father's authority becomes common. The newer family follows the Western form -- greater equality of the sexes, more overt display of affection and their father is less distant and authoritarian toward the children.

Rapid culture changes can have seriously damaging effects on mental health, so much so that the "decultured" man stands alone and takes the whole burden of success and failure upon his own self. If he can't achieve a new and satisfying way of life, he becomes frustrated and threatened. He may find himself in such a position that he breaks down under the strain. It is apparently the second generation of Triolet that is showing the worst features of deculturation; loss of identity, behavior disorders, delinquency and psychoneuroses.

042 -- NEW ZEALAND -- MAORI

Blake-Palmer, G.

The incidence of schizophrenia in Polynesians with special
reference to the Maori people of New Zealand

REPORT OF THE 2ND INTERNATIONAL CONGRESS FOR PSYCHIATRY
(Zurich) 1:85-86 (Sept. 1-7, 1957)

The overall incidence of psychoses, incapacitating neuroses, and other psychiatric disorders necessitating

admission to mental hospitals is significantly lower in the Maori population than in non-Maori groups. In the Island territories and other Polynesian areas from which information has been collated there is a corresponding low incidence of manifest and incapacitating psychoses and neuroses. Polynesian regions of greater physical activity like Nieu show the lowest incidence of psychiatric disorder. The principal material on which this study is based is all Maori admissions to mental hospitals in New Zealand for the years 1953 to 1956 (492 admissions relating to 439 individuals). The Maori population mean from which the rates (per 100,000) were taken is calculated as of 31 December 1954.

The age structure of Maori populations differ strikingly from non-Maori. Half the New Zealand population is under 21 years of age and only 2% of the population is over 60. With the adjustment for age structure, the incidence of schizophrenia is slightly lower than that of the non-Maori and that for depressive states and especially for senile psychoses and alcoholism is strikingly lower.

Were one to examine the "length of stay" in hospitals, it would be seen that the Maori have a hospital stay which amounts to only about one-half of that for non-Maori. In Maori communities where the soil and situation call for greater effort and work -- as on Niue Island -- there is an even lower incidence of schizophrenic psychoses requiring hospital care.

Maori social structures and customs permit an easier reassimilation of the patient in his own community.

043 -- NORWAY

Eitinger, Leo

Incidence of mental disease among refugees in Norway
JOURNAL OF MENTAL SCIENCE 105:326-38 (Apr. 1959)

Presents a survey of mental disease among refugees in Norway for the period 1946-55. The task of estimating the refugee population in Norway during this period of observation was extremely difficult, since no registry had been established before 1951. Refugees who arrived before or left before this date were included in the large number of tourists, seasonal laborers, artists and others who visited the country. From a study of various

(NORWAY -- contd.)

institutions engaged in work with displaced persons and later refugees, Dr. Eitinger determined that the average refugee population for the ten year period was 1,879 persons comprising 1,415 males and 464 females. Sixty individuals, or 3.19%, of the total refugee population became psychotic during the period of observation. There were 14 cases of schizophrenia or an incidence of 0.74%. The observed incidence for all diagnoses comprising both sexes of the refugee group was 5 times higher than could be expected in a corresponding general population group for the country of Norway.

Statistics are also given regarding displaced persons brought to Norway during World War II. This number was estimated at being 764 with an incidence of schizophrenia of 1.31%. There was a marked difference in the rate of schizophrenia for these two groups, 0.74% for the refugees and 1.31% for the displaced persons.

It is pointed out that psychoses among immigrants, especially schizophrenia, seems to be a factor that increases tendency toward migration. By and large, the greater number of schizophrenics in immigrants to the U.S. occurs 5 years or more after immigration. Hence, if environmental stress is the main cause of schizophrenia, it follows that the disorder among immigrants would be evident in 5 years. Although virtually the opposite is true in the present study (11 of 14 cases were apparent during the first five years), the author contends that a number of variables in the present study account for this difference. First, the individuals in the present study were not immigrants but refugees who in truth were a "minus selection" of immigrants. Besides the forced laborers who remained in Norway subsequent to 1945, the refugee population was largely composed of the disabled and the ill, who were unsuitable for "emigration" to other countries.

044 --

Ødegard, Ø.

Epidemiology of schizophrenia in Norway

REPORT OF THE 2ND INTERNATIONAL CONGRESS FOR PSYCHIATRY
(Zurich) 3:49-52 (Sept. 1-7, 1957)

States that schizophrenia has a varying distribution within the population. This distribution has been studied in some detail using first admissions to psychia-

tric hospitals as material. This statistical approach has the advantage that in such a segment of society there is an abundance of material. As an example, a comparatively simple mental morbidity has to consider the factors of sex, age, and mental diagnosis, which means a subdivision of the material into something less than 96 and 320 subgroups. This is hardly possible by any other method. The shortcomings of this method (first admissions method) are so obvious as to present certain inaccuracies. For instance, certain cases are not admitted to mental institutions because they are ambulatory or perhaps their mental disturbance has not reached a stage as to warrant hospitalization, or still further, there may be a shortage of available beds. In a final evaluation of hospital admission statistics, Dr. Ødegard states that they lead to very much the same figures as most census investigations. For all diagnostic types of psychoses together, the morbidity is about 1%. The author has found an association between schizophrenia and unfavorable or exposed environmental conditions. Within such exposed groups a certain number of individuals yield to some sort of social pressure. As a result of this, the schizophrenics are to be found among the single rather than among the married, and in under-privileged or declining occupations rather than the opposite.

For schizophrenia, the most striking difference was found between the single and the married, the morbidity (for instance, on admission) being four times as great in the single. The widowed occupy an intermediate position. This suggests a connection between schizophrenia and a social status which is somehow unfavorable or appears as a result of some personal handicap. When different occupations are compared, a corresponding pattern emerges. Schizophrenia is generally more common in persons with occupations which do not demand education, training and who have a low level of social prestige and competition. The admission rate is 43% higher in farm hands.

When different parts of Norway are compared, variations are not so greatly pronounced and are for the most part hardly significant. There is a possible maximum in the south-west, with decreasing admission rates as one goes east or north. During World War II, the incidence of schizophrenia and allied mental disorders decreased in Norway, while manic depressive psychosis on the one hand and senile and organic psychoses on the other remained stationary. At that time, the German occupation represented a decided increase in the total mental stress. One might

(NORWAY -- contd.)

therefore conclude that schizophrenia is not over-responsive to these changes. Stress of this type may reverse introversion and improve inter-personal contact by offering an outlet to aggressive tendencies. This may be a key to the problem as to what type of stress, if any, is apt to influence the outbreak of schizophrenia.

045 -- PUERTO RICO

Fernandez-Marina, R. and von Eckardt, U.
Cultural stresses and schizophrenogenesis in the mothering-one in Puerto Rico
ANNALS OF THE NEW YORK ACADEMY OF SCIENCES 84:864-77
(Dec. 8, 1960)

Describes certain biological, psychological, and sociological phenomena in the mathematical metalanguage of propositional calculus, and of the algebra of classes. The authors propose certain definitions and relational axioms that will make it possible to formulate the dynamics of the interaction of the above phenomena with the clarity and precision made possible by mathematically structured statements. Today one cannot state that the behavioral sciences are handicapped by their atomization, i.e., by the fact that psychiatry, medicine, anthropology, sociology, and experimental psychology have each established a separate realm within the universe of discourse with specific definitions, vocabulary, methodological orthodoxy, and collective representations. By and large, one can say that the instrument of mathematical logic, a 20th century development, has done much toward bringing about the union of physical and natural sciences. Due to this methodological analysis, natural science has acquired more knowledge within the last 50 years than during the previous 50 centuries. In the present paper, an attempt has been made to enunciate some basic concepts in the psychiatric and psychoanalytic disciplines according to the universal scheme of mathematical forms. The concepts implicit in this paper were first empirically explored by Sigmund Freud, Harry S. Sullivan and Freida Fromm Reichmann. No attempt has been made to prove these concepts true or false.

The specific cultural stresses operative in Puerto Rico are more or less dependent on the dictum "ontogeny recapitulates phylogeny" which marks the evolution of the genus Homo sapiens. This process, particularly in the beginning, requires an abundance of energy which is essentially supplied by the mother. The topographical

and algebraic formulations presented in the present paper provide the "conceptual unity" and the invisible connectedness between supplied facts and premises. In more than 25 years of clinical experience in Puerto Rico, the following cultural factors in the families of schizophrenics have been noted: (1) The mothering-one has a deformed ego because she is the daughter of a narcissistic and seductive woman and an aloof and rigid father whose strong sense of morality keeps him in the home and encourages him to protect his wife. The ego deformations of the mothering-one shadow those of her narcissistic mother. (2) The mothering-one is married to a weak and ineffectual man who threatens her at the moment of the infants birth with loss of love and loss of prestige. This threat constitutes a specific stress that breaks down the precarious isomorphism of her deformed ego.

There are, therefore, three conditions of schizophrenogenesis: (1) The ego of the mothering-one must be deformed, (2) she must be subjected to specific stresses, and (3) the infant must be handicapped by certain inherited factors.

046 -- _____

Maldonado-Sierra, E. D. and Trent, R. D.
Sibling relationship in group psychotherapy with Puerto Rican schizophrenics
AMERICAN JOURNAL OF PSYCHIATRY 116:239-43 (Sept. 1960)

Summarizes one way in which a group psychotherapeutic process was made more culturally relevant for Puerto Rican schizophrenics. A 3-member therapy team representing the significant members of a family (father, mother, and older sibling), was employed with each group of patients. Attention was focussed upon the sibling's relationships in the therapy team and the ways in which the sibling's therapeutic maneuvers were employed in overcoming the intricate difficulties of establishing meaningful communication with the patients. The sibling's transactions in verbalizing the unconscious of the schizophrenic to the mother and father figures results in a rapid resolution of resistance for what was formerly deemed dreadful and secret, and which through repeated sibling verbalization gradually acquires the appearance of the commonplace.

047 -- SOUTH AFRICA -- BANTU

Moffson, A.

Schizophrenia in male Bantu admissions to Weskoppies Hospital, Pretoria (South Africa)

SOUTH AFRICAN MEDICAL JOURNAL 28:662-66 (#32, 1954)

Records a study involving 227 male Bantu schizophrenics admitted to a South African mental hospital over a period of some 14 months. The South African is in the throes of a social and cultural revolution. Most of the patients were detribalized migrant laborers. The absence of a reasonable history prior to admission, in the vast majority of cases, was a tremendous drawback in the assessment of diagnosis and prognosis. The outcome of these cases as determined three months following completion of this study is reported, and the results of ECT given to 170 of these cases are analyzed. The overall results were poor, and it is suggested that the type of case that did get admitted was only too often the chronic one, where the prognosis is worst. The catatonic and hebephrenic patients were divided into two groups, as regards the general type of behavior on the ward: (a) noisy and excited, and (b) quiet and withdrawn. Fifty-five per cent of the "noisy and excited" schizophrenic catatonics remitted, as compared with 18% of the "quiet and withdrawn" ones, while the comparative figures for the hebephrenic group were 57% and 17% respectively. Thus, a general pattern of ward behavior which may be described as "noisy and excited" might be used as a favorable prognostic indication in male Bantu catatonics and hebephrenics. Differences between male Bantu and male European psychiatric practice in South African hospitals are touched upon. (Adapted from author's summary.)

048 -- -- ZULU

Lowenstein, H.

Juvenile schizophrenia

SOUTH AFRICAN MEDICAL JOURNAL (Capetown) 33:449-50
(May 30, 1959)

Reviews briefly schizophrenia in an African juvenile. This is a condition which the author has not found described in the literature. The case discussed is that of a Zulu lad aged 13 who was admitted to Fort Napier in May 1955 for a period of eighteen months. Mentally, he was fatuous, fidgety and manneristic, appeared confused,

and replied to questions either by grinning, or repeating the question. His intimate habits were faulty, but some days he could manage to keep his trousers dry and clean. He would bite himself impulsively and throw stones repeatedly, but aimlessly.

Because of the heterogeneity of schizophrenia, various figures are quoted for juvenile schizophrenia. Meyer-Gross (in Clinical Psychiatry--1954) makes the following comments: "Schizophrenia is probably no more frequent than manic depressive psychoses in children, but the diagnosis is more frequently made. Recently, the general trend has been to diagnose all mental conditions seen before puberty as schizophrenia." By and large, the real incidence of childhood schizophrenia is very low. Many experienced psychiatrists have never seen a schizophrenic patient younger than 11 years of age. Bender, on the other hand, (in Excerpta medica--1953) says that 6,500 children up to 13 years of age, seen by psychiatrists of Bellevue Hospital, New York, included 626 diagnosed as schizophrenia. Of these, 5% were less than 5 years of age. However, this figure is apparently based on a selected population and therefore does not reflect the illness in the general population. In an annotation (in Lancet 1:551--1955) it is suggested that schizophrenia in juveniles is not as rare as previously believed. Puzzling nomenclature is said to be an important factor in this situation. Finally, Carothers, Kallmann, Smart and others have noted a sex incidence relevant to a preponderance of males as adverse to females in juvenile schizophrenia. Generally considered, the prognosis of childhood schizophrenia is extremely poor.

049 -- SOUTH EAST AFRICA -- NYASALAND

Shelley, H. M. and Watson, W. H.
Schizophrenia in Nyasaland
in WHO MONOGRAPH SERIES 17:141 (1953)

Quotes the authors as saying in Journal of Mental Science 82:701 referring to Nyasaland: "The most important features of schizophrenic psychoses in this country are the high incidence of such disorders as compared with other types, their close relationship to Europeanization, as shown by tribal, district and educational distribution, the high incidence of the European type of delusions, and the high rate of sexual disturbances."

050 -- SOUTH WALES

Carstairs, G. M. and Brown, G. W.

A census of psychiatric cases in two contrasting communities
JOURNAL OF MENTAL SCIENCE 104:72-81 (Jan. 1958)

Records results of an assessment of psychiatric morbidity in two towns, Rhondda and Vale, in South Wales. Rhondda has a population (1951) of 19,722 while Vale has a population of 4,621. Both populations reflect a count of persons over the age of 15. Although these towns are not located very far apart, they exhibit markedly contrasting social traits. People from Rhondda, a mining community, are "rougher," more prone to drunkenness, to violence, to petty crime, and to immorality, more talkative, more belligerent, than those from Vale, who were left-wing and puritanistic. Hence, it was expected that psychiatric illness would be greater in Rhondda. However, this study did not confirm these expectations: All three men from Vale who were mentally ill were schizophrenics as were 32 out of 52 psychiatric cases from Rhondda. In women patients, schizophrenia was diagnosed in 3 out of 9 cases from Vale and in 23 out of 29 cases from Rhondda. When diagnoses were analysed, men from Rhondda greatly exceeded those from Vale in morbidity statistics. As regards sexual incidence, diagnoses for schizophrenia are similar for the two populations for both sexes. Actual figures for female schizophrenic out-patients show Rhondda, 6; Vale, 3. An analysis of the diagnoses of men admitted to mental hospitals for the 5 and one-half years covered by the present study shows the main differences between the two groups are in the categories schizophrenia and psychoneuroses; the rate of schizophrenia being 4 times greater than that of psychoneuroses. The incidence of schizophrenia was 9 times greater in non-miners.

051 -- SWITZERLAND

Roth, G.

Etude de la fertilité de 300 meres de schizophrenes
A study of the fertility of 300 mothers of schizophrenics
ACTA GENETICA ET STATISTICA MEDICA (Basel, Schweiz)
9:284-305 (#4, 1959)

Analyses a series of 369 cases of schizophrenia admitted to the Bel Air Clinic to determine the fertility of mothers of schizophrenic patients. The scope of this study covers a span of 10 years. The diagnostic criteria

established for selection of these schizophrenics are described. By and large, some 300 case reports yielded sufficient information concerning the mothers and siblings of the patients and were therefore used in this study. The research material was divided into two groups according to the clinical symptomatology of the patient subjects: (1) the dementia praecox group (D.P.) comprising the hebephrenics and catatonics, and (2) the paranoid schizophrenic group (S.P.). Furthermore, patients of foreign origin were analyzed separately. The mean age for onset of psychotic symptoms in the D.P. group was found to be 27.1 years, and the mean age of first admission was 28.9 years. Corresponding data for the S.P. group were found to be 44.8 and 48.4 years. A comparison between the fertility of the mothers of schizophrenics and mothers in the general population was effected, paying due respect to the known variations of fertility due to age and time. The greater proportion of the mothers had reached the menopause. The distribution of sibships according to size and mean number of children per sibship exhibited no significant difference from that of the general female population. Only live births were considered. Fifty-three of 114 D.P. families and 39 of the S.P. families gave a history of one or more additional cases of psychoses. The mean number of sibs of the S.P. patients was higher when other psychotics were found in the family. Of 60 S.P. patients who had passed the reproductive stage and were investigated for fertility, seventeen were unmarried and fifteen had never been gravid. The married S.P.'s patients averaged 1.14 children each compared with a normal value of 3.13. This observation varies considerably from previous investigations of this kind.

052 -- THAILAND

Ratanakorn, Prasop
Cultural anthropological studies as related to the nature of schizophrenia
 REPORT OF THE 2ND INTERNATIONAL CONGRESS FOR PSYCHIATRY
 1:284 (Sept. 1-7, 1957)

Gives a pre-publication abstract of an article to be published later in the Journal of International Psychiatry. This abstract concerns Thailand, which like most countries in the Orient, is affected by one of the world-wide disorders, schizophrenia. This condition is the most frequently encountered of all mental diseases and probably

(THAILAND -- contd.)

the most variable in its manifestations. In 1953, 72% of a population of 18 million were schizophrenics.

The following facts were discovered in a study of this condition: (1) Age -- 75% of the cases of schizophrenia studied begins between the ages of 15-25 years. (2) Sex incidence: 63.67% of cases are male and 36.33% were female. (3) Sexual life: More than likely the regressive attitudes associated with sexual experience enter into the genesis of schizophrenia. (4) Organic concepts: (Physical-anthropological aspects): The majority of people are comparatively short in stature, Kretschmer's Asthene (Leptosome or Schizoid) type. This is true in about 54% of the cases. (5) Cultural Anthropological Studies: These studies reveal 3 factors which produce schizophrenic-like personality among the Thais; culture, customs and mother-child relationships.

The author states that it is quite noticeable to see that Thai children are often in the arms of one or the other of their parents. Their feeding seems close to demand feeding. Children are taught, in an insistent but apparently gentle way, to be respectful of their elders. Some children are drilled to express attitudes that are even submissive. On the other hand, most of the people live and think in traditional ways. In this country, Western ways have scarcely affected the lives of ordinary people.

Adherence to Buddhist teachings is overwhelmingly prevalent and sincere conflict is inevitable. Other general trends, clearly projected in old ballads, "In water we have fish, in the field we have rice" -- an economic situation which encourages ease and complacency. This is the general characteristic of a schizoid temperament. Other anthropological views are discussed and presented.

053 -- _____

Ratanakorn, Prasop

Studies of mental illness in Thailand

McGILL UNIVERSITY REVIEW AND NEWSLETTER 7:27-28 (Jan. 1960)

Presents a review of a 64 page book which involves a study of some 2,088 patients in a mental hospital in Bangkok, Thailand, during the year 1953. By and large, a good part of the book is devoted to a statistical survey of these patients. Significant of the results

(THAILAND -- contd.)

obtained through this study, the high incidence of schizophrenia stands in the forefront (72% of all admitted cases). An interpretative assay of these findings, based on a number of cultural factors, is presented. The family in Thailand constitutes a large group of 30-40 persons under strict patriarchal authority; difficulties are often settled in a family council. This type of counseling should help the individual to solve his problems without experiencing loneliness. Dr. Ratanakorn believes that these factors tend to provide a protection against emotional disturbances.

Buddhism, the national religion of Thailand, exerts a profound effect upon the individual. It teaches the individual to search for the true realization of the self. Too, it promotes non-violence, non-aggressiveness, forgiveness and prompt overthrow of frustration. Every young male adolescent is obliged to spend 3 months in a Buddhist monastery as a compulsory part of his education. This is one of the few times in the life of the Thailand male in which he is not under complete family dominance. The Buddhist world-view might explain the shyness of most young men and the prevalence of schizophrenia.

054 -- UNITED STATES -- IRISH AND ITALIAN

Opler, M. K. and Singer, J. L.

Ethnic differences in behavior and psychopathology in the Italian and Irish

INTERNATIONAL JOURNAL OF SOCIAL PSYCHIATRY 2:11-23
(Jan. 1956)

Continues the senior author's careful investigation of cultural factors as determinants of both aetiology and the content of schizophrenia. Ten hypotheses were postulated based upon expected differences in illness, history and symptomatology of 2 contrasting cultural groups, the Irish and the Italian in New York City. From detailed studies of the histories, by interviews and by psychological testing of 40 male Irish and 37 male Italians, these hypotheses were confirmed. Basic and distinctive cultural patterns, particularly in the institution and family, were found to exist in the illness processes of each group. The primary one in the Irish group was a dominating, rejecting mother and an evanescent father, while in the Italian group a dominating father and older siblings, and a warm mother. Marked differences were specifically found in the following areas thus pointing to differences in the aetiology and content of the illness: (1) primary anxiety

(UNITED STATES -- contd.)

or hate; (2) resolution of homosexual trends; (3) channeling of emotional expression; (4) behaviour disorders; (5) attitude to authority; (6) fixation of delusional system; (7) somatic preoccupation; (8) alcoholism. This paper demonstrates the need for continued collaboration between the anthropologist, the psychiatrist, sociologist and the psychologist.

055 -- -- IRISH AND ITALIAN

Opler, Marvin K.
Schizophrenia and culture
SCIENTIFIC AMERICAN 197:103-10 (1957)

Presents a comparative analysis of schizophrenics from Italian and Irish groups in New York City. The Irish patients were "fearful of females," low in self-esteem, tortured by feelings of guilt and inadequacy, and sunk in "paranoid delusions." The Italian was seen as "hostile to male figures", overtly homosexual, extremely impulsive and excitable, subject to moods of depression or uncontrolled elation, and sometimes assaultive and destructive. The symptom pictures derived from interviews and tests were related to studies of family life in the areas of the city from which the subjects came.

056 -- -- BOSTON AND NAPLES

Parsons, Anne
A comparison between Italian and "Yankee" schizophrenics
MCGILL UNIVERSITY REVIEW AND NEWSLETTER 9:43-50 (Dec. 1960)

States that Dr. Parsons has for the past four years been engaged in a comparison of schizophrenia manifestations between Italian and U. S. patients. Her studies were carried out first in Boston and as far as the Italian patients go, in their home environment in Naples. The present contribution is an abstract of the doctor's work on this theme.

In this paper it is pointed out that when the schizophrenic is considered in his cultural context, it is extremely easy to find features of his illness and personality which make sense in particular terms. At the same time, there is also considerable evidence to indicate that schizophrenia may be diagnosed under a wide variety of sociocultural conditions, i.e., that there is always something the same about all schizophrenics regardless of cultural background. When Dr. Parsons went to Italy

she had the following questions in mind: (1) To what extent is psychiatric diagnosis actually describing the same phenomena when used cross-culturally? (2) If there are features of schizophrenia which occur in all cultures, what are they? (3) What specific features might vary in relation to cultural characters? By and large, it boils down to the question of whether the diagnosis of schizophrenia is used in the same way in Boston as in Naples. In considering family schizophrenia in the light of the Italian material, it was postulated that symbiotic dependency was characteristic of the condition.

The data presented in this paper also stimulated consideration of a number of assumptions. One of these is that South Italian patients might break down only on the death of a crucial person (i.e., the mother) after having adapted fairly well on a dependent basis previously. The study has also pointed to ways in which microscopic variations in family structure may have importance. A picture of variance between urban and rural cases is given. The urban lower-class Neapolitan family is in many ways a very individualistic unit. Finally, it was felt that further comparative studies on schizophrenic families can be of crucial importance in psychiatric research, especially in that comparative work may help the psychiatrist to avoid judging family patterns as pathological, simply because they do not conform to his own expectations. Nevertheless, this work points to many similarities between schizophrenic patterns seen in Southern Italy and in the United States. It also reveals that the anthropologist studying pathology should be particularly careful to avoid the opposite fallacy of considering behavior "normal" simply because there is some correspondence on which to pattern the relevant culture.

057 -- _____ -- MULTICULTURAL

Opler, Marvin K.

Cultural perspectives in research on schizophrenias:
a history with examples

PSYCHIATRIC QUARTERLY 33:506-23 (July 1959)

Describes a group of disorders known as the schizophrenias which have an insidious and disastrous course and which have long plagued and perplexed psychiatrists. In the present paper the historical background, together with factors pertaining to the etiology, symptomatology, diagnosis,

pathology, epidemiology, social, racial, and cultural perspectives of this syndrome are traced. In 1944, Klopfer and Malzberg reported finding different frequencies in major mental illnesses among such groups as Italian, Irish and German immigrants. In the same year, R. W. Hyde and associates noted the incidence of mental illness in Selected Service rejectees. Again such groups as persons of Chinese, Irish, Italian, Jewish, and Portuguese derivation were compared, although unfortunately such gross diagnostic categories as psychoses, neuroses, mental defects, psychopathic personality were used. Only studies by E. Stainbrook in the Bahian region of Brazil or J. C. Carothers' compendium of African data discuss schizophrenia centrally and even these authors discerned diagnostic variations even more than differences in the etiology and the developmental course of the disease. As extensions of our knowledge of the psychotherapy of the schizophrenias, it has been said that interpersonal relations as well as stresses implicit in various cultural backgrounds are basic to different disease processes. In 1954-55, Dr. Opler initiated a study of hospitalized schizophrenic samples of backgrounds from a section of New York City involving Irish, Italian, German, Hungarian, Czech, Slovakian, Puerto Rican and older American types.

The samples used in this study were hospitalized male and female schizophrenics from this same area of New York City and were all of Irish or Italian background. These samples of female schizophrenics were inadequate statistically, but interesting on psychodynamic grounds. The census of male patients comprised 40 Irish and 37 Italian schizophrenic patients. After all patients had been seen and interviewed by both anthropologists and psychiatrists and their complete hospital records studied, they were then subjected to a battery of psychological instrumentation, including Rorschach, Barron's Movement Threshold Inkblots, the Porteus Maze, the Thematic Aperception Test, Time Estimation and Motor Inhibition, the Lane Sentence Completions and other behavioral ratings. Ten Irish and 7 Italian patients were too ill to complete the tests. The remaining 60 subjects, 30 Irish and 30 Italian, were intensively studied by psychiatric, anthropological and psychological methods.

An analysis of the variables matched or controlled for both samples included: age, sex, level of education, intelligence, marital status, first year of hospitalization,

and absence of organic or chronic conditions. Only marital status in the Irish showed a culturally influenced bachelorhood excess. All the Italians but one traced their lineage from the extreme south of Italy or Sicily. All the Irish were from countries in Southwest Ireland. The lone North Italian proved an exception to the Italian group in both psychodynamic and cultural patterns. Twenty-seven of 27 Irish males showed a latent homosexuality with no overt practitioners. On the other hand, 20 out of 27 Italians were overt homosexuals. Sin and guilt preoccupations were present in 28 of 30 Irish males and absent in 21 of 30 Italians. Behavior disorders were present in 23 of 30 Italians and absent in 26 of 30 Irish. Twenty-four Irish showed a compliance for authority while 21 of 30 rejected it in the Italian group. As regards alcoholism, 19 of 30 Irish patients were chronic alcoholics whereas but 1 of 30 Italians were alcoholic. Some fixity in delusional system was exhibited in the Irish while but a small amount of fixity was present in the Italians.

The different patterns revealed by this investigation are considered to be the result of a certain fundamental difference between the 2 ethnic groups. Although the mother appears to be a dominant figure in Irish families, authority lies more in the hands of the male parent or eldest male sibling in Italian families. Italian culture encourages a freer expression of emotions, verbally and even through bodily action. On the other hand, the Irish although more restricted in activity compensate this by a richer fantasy life. Dr. Opler points out that knowledge about such cultural differences and their influence on symptom formation in mental illness can not only help in the theoretical understanding of schizophrenia, but also in the successful practical management of such patients when they are hospitalized.

058 -- _____ -- NEGRO IN N. C.

Vitols, M. M.

The significance of the higher incidence of schizophrenia in the Negro race in North Carolina
NORTH CAROLINA MEDICAL JOURNAL 22:147-58 (Apr. 1961)

Deals primarily with the comparative incidence of schizophrenia in the negro and white races in North Carolina. The first admissions of white patients to the

state hospitals at Raleigh, Morgantown and Butner are compared with the first admissions to the only Negro State Hospital at Goldsboro. If we postulate that the incidence of schizophrenia is greater in the Negro race than in the white race, it is necessary then to determine the factors responsible for this difference: (1) the possibility of heredity as a causative factor may be questioned. The author states that he does not discuss this factor because of lack of material. (2) The socioeconomic factor is, however, discussed and since a larger number of the Negro first admissions are from a lower socioeconomic level, this factor is felt to be one of the causative factors of the high level of specific and basic frustration in the Negro. (3) Too, it is felt that the genetic and dynamic forces stemming from his specific family structure exposes the Negro to great and frequent frustration from early childhood. (One is always impressed by the amount of frustration and futility mixed with a certain degree of hostility involved in talking about the mother. Also, because of the above factors, the father is unable, being the weaker and more unstable member of the family, to give emotional support to the growing child. This results in hostility toward the father and authority figures in general, with resentment toward the whole world and particularly toward members of his own race in whom he sees and hates his own image. These specific forces in the Negro, closely interrelated with cultural, interpersonal, and economic pressures, are stress factors and may be responsible for the higher incidence of schizophrenia in the Negro race.

059 -- _____ -- NEGRO IN N. Y. STATE

Malzberg, B.

Marital status and mental disease among Negroes in New York State

JOURNAL OF NERVOUS AND MENTAL DISEASES 123:457-65
(Mar. 1956)

Discusses rates of mental disease among Negroes as measured by first admission. These rates vary according to marital status. In general, rates were higher in the single. Schizophrenia formed 45% of first admissions among the single group, as compared with 25.3% in the married group. This type of mental illness occurred in 30.1% of first admissions among the separate and divorced. This percentage is less than that for the single group, but in all other major psychoses their rates of admission were higher than for singles.

Malzberg, B.

Mental disease among Negroes

MENTAL HYGIENE 43:422-59 (July 1959)

Presents an analysis of the frequency of mental disease among Negroes, based upon first admissions to all hospitals for mental disease in New York State during the three years beginning October 1, 1948, and ending September 30, 1951. Comparisons were made with similar admissions during the previous decade. Further comparisons were made with the white population of New York State during the same period. First off, Dr. Malzberg concludes that there are no differences between Negroes and whites with respect to mental disease, i. e., there are no mental diseases which are strictly limited to either culture. The same mental diseases occur among both races but in different relative frequencies.

By and large, the outstanding diagnostic category revealed by this study is dementia praecox. A total of 45.2% of the Negro first admissions were included in this group, compared with 26.9% of whites. This difference was produced in part by the different age structures of the population. On the basis of this difference, Negroes had a rate of 325.8 per 100,000 compared with 153.8 per 100,000 in all categories of mental illness. Except for dementia praecox and involutional psychoses, there was a decrease in the rate of first admission among Negroes between 1940 and 1950.

Dementia praecox is primarily a disease of the young. More than one-half of the Negro first admissions admitted in this category were under the age of 30 years. The author's statistics show that there were very few admissions for dementia praecox under age 10, but at ages 10-14, there was an average annual rate of 50.4. This increased rapidly to a maximum of 202.3 at ages 20-24 and then decreased steadily with advancing age. Through ages 30-34, male rates with one exception exceeded female. Beyond age 35, females had higher rates. The excess of these rates for females increased with advancing age.

The greater majority of these differences are explicable, however, on the basis of migration and environment. Negroes in New York State are a highly migratory population, 60% having been born outside the State, compared with 14% of the white population. In addition, Negroes

suffer from low standards of living, owing to economic disabilities. These disabilities were evidently less severe in 1950 than in 1940 as measured by economic and educational advances and by wider dispersion of the Negro population within New York City. These conditions have reduced in general, the rates of first admissions among Negroes, and therefore point to the possibility of further improvement in mental health in Negroes in New York State.

061 -- _____ -- NEGRO IN VA.

Wilson, D. C. and Lantz, E. M.

The effect of cultural change on the Negro race in Virginia as indicated by a study of state hospital admissions
AMERICAN JOURNAL OF PSYCHIATRY 114:25-32 (July 1957)

Points out that there are so many reasons why patients stay in hospitals, that it was thought best for purposes of this investigation to study admissions only. Hence, a study was made to show a summary of first admissions and readmissions of mentally diseased, mentally defective and epileptics in Virginia according to race and rate per 100,000 of population for the period 1914 to 1954. The following pertinent data are set forth: (1) There has been a larger ratio of Negroes admitted to state hospitals per 100,000 population of Negroes than of white per 100,000 white population over this span of 40 years. (2) There has been an increase in rate of schizophrenia in the white population which in later years was followed by lessening of the schizophrenia diagnosis. Comparatively, however, for the entire period the Negro has a greater incidence per 100,000 of population. (3) First admissions of Negroes with the diagnosis of schizophrenia cannot be too reliable an index for this ratio of race and rate, because due to his socioeconomic status the Negro is more inclined to transfer older members and mentally ill patients to the care of the state. The rate per 100,000 of schizophrenics for the whites changed from 6.4 in 1920 to 7.2 in 1955, while the rate for Negro admissions in the schizophrenic group increased from 12.0 in 1920 to 21.7 in 1955. The study indicates that the decline in state hospital admissions for the white race is due to the increase in the use of other facilities, for the care of the mentally ill. The rate per 100,000 population for the Negro race is still higher, but what is to be expected from the study of previous years. Before 1940, the private institutions and psychiatric wards in general hospitals, which play such a large part in the incidence of mental disease, reported for these two groups,

were of minimal significance. Admissions to all types of hospitals within the state of Virginia parallel in their behavior most closely the reported incidences and changes in ratio. The Negro has experienced similar changes to those in the white during this period with two additional factors: segregation has become more severe; and he is no longer the servant but the equal of the white. It is believed that the cause of the increase in mental illness from 1914 to 1954 is due to segregation in large part, and also to the uncertainties of the Negro race as they cross from one culture to another.

062 -- U. S. S. R.

Feodotov, D.

Psychiatric facilities in the U.S.S.R. (letter)-- translated from Russian

McGILL UNIVERSITY REVIEW AND NEWSLETTER 8:57 (July 1960)

The present letter was written in relation to trans-cultural research in mental health. At the present time in the U.S.S.R., there are 119 dispensaries. In addition there are 2,467 psychiatric clinics (started in 1957) with 126,180 psychiatric beds. This number does not include those in organizations of social welfare, or beds for children, oligophrenics, and those belonging to the Ministry of Education. Many general hospitals have psychiatric wards, and patients with minor psychiatric ailments are treated in special sanatoriums.

A table showing some 17 types of psychiatric diagnoses is presented. Percentages showing the incidence of these various types of mental illnesses are given. Schizophrenia shows by far the greatest incidence. Figures embracing the years 1950-57 indicate that schizophrenia constitutes approximately 35% of all mental illness.

063 -- _____

Wortis, Joseph

A psychiatric study tour of the U.S.S.R.

JOURNAL OF MENTAL SCIENCE 107:119-56 (Jan. 1961)

Relates experiences as an invited guest in the U.S.S.R. where he was allowed complete freedom to examine any or all of the various mental hospitals throughout the Soviet. Dr. Wortis states that when he asked about the

(U. S. S. R. -- contd.)

general incidence of psychiatric disease in the U.S.S.R., he was given the following information: In 10 major psychiatric hospitals in the Ukraine, a comparison was made between the pre-war and post-war periods. In the post-war period there appeared to be a slight increase in the number of schizophrenics, and 52% of all hospitalized psychiatric patients were now so (schizophrenia) diagnosed. Only 21% of these schizophrenics were first admissions; 22% were second admissions, and the remainder, third admissions. The number of schizophrenic first admissions had actually decreased slightly. Their main problem was actually the relapsed and chronic cases. The author appears interested in what the Soviet psychiatrists called the "hypoxic theory of schizophrenia" in which a number of treatments had been developed utilizing low oxygen pressure, both in low pressure chambers and at high altitudes. In a series of 30 predominantly chronic cases who were sustained at 4,000 m. for a month, behavioristic abnormalities were seen at the termination of high altitude. Before Wortis left the Soviet, he was shown a motion picture film depicting the changes in behavior in these chronic schizophrenias at such heights. By and large, the results of this procedure seemed very encouraging. There was no doubt that a number of the experimental subjects had improved as a result of the experience, but it was difficult to determine whether the improvement was strictly attributable to low oxygen tension. In Kiev, where this study is taking place, most psychiatrists regard schizophrenia as a specific disease entity, but that opinion on this subject is sharply divided elsewhere in the U.S.S.R.

064 -- WEST AFRICA (GHANA)

Field, M. J.

Mental disorder in rural Ghana

JOURNAL OF MENTAL SCIENCE (London) 104:1043-51 (Oct. 1958)

Summarizes the principal findings of two years' ethno-psychiatric case work carried out in N.W. Ashanti throughout the years 1956-57. In rural Ghana shrines (very few of which are ancient) are to be found. Such shrines have been founded in response to a search for security begun about 40 years ago. One of the commonest mental illnesses seen at these shrines is schizophrenia. Too, one should realize that potential schizophrenics are especially vulnerable to transient fear psychoses. The making of bad magic against others is a schizoid type of aggression particularly prone to occur in developing

schizophrenia among supplicants at shrines. Dreams are deemed highly important. Persons in similar anxiety charged situations, often have identical dreams of traditional content. Most dreams sum up the dreamer's overt situation in parabolic metaphor. Hysterical dissociation (spirit possession) is part of the technique of priests, these being well adjusted, non-hysterical personalities. This phenomenon is used therapeutically by some African-controlled Christian communities. It is postulated that some kinds of magical ritual, animal totemism, and the malevolent powers attributed to witches were originated historically by schizophrenics.

Certain factors relevant to Ghana culture are illustrated by the following incidence statistics: (1) The incidence of schizophrenia in a rural population of 4,000 was found to be about 1%. (2) The incidence of literacy among these schizophrenics was found to be about 40% as against 10% in the general population. (3) The incidence of first cousin marriages among the parents of schizophrenics was found to be about 40% as against 19% among the general population.

065 --

Forster, E. F. B.

Schizophrenia as seen in Ghana

REPORT OF THE 2ND INTERNATIONAL CONGRESS FOR PSYCHIATRY
(Zurich) 1:151 (Sept. 4, 1957)

Covers a cross-section of the populations from all regions, from the primitive to the Westernized African, studied mostly at the only mental hospital in Accra, Ghana. In the hospital, 36% of the patients were schizophrenic, the average age being 32 years. By and large, the greater incidence was found in the more highly Westernized south. The etiology of this situation is to be found in the fear of compulsory hospitalization and family "pride." Dr. Forster is of the opinion that environmental factors (superstitious beliefs, primarily an unwholesome family system of dependency and poverty) merely precipitate an illness for which the patient already has a predisposition.

The basic reaction type of mental disorder is the same everywhere, but environmental and constitutional factors somewhat modify the picture. In Ghana, culturally patterned orientations of thought, such as beliefs in magic and spirits, ancestor worship, and the pronounced system of family dependency are all factors which effect the system constellation.

(WEST AFRICA -- contd.)

The largest number of patients are from the south -- the most progressive, most Westernized region. There has been a steady rise in the admission rate from 3 per 100,000 in 1940 to 10 per 100,000 in 1953, and the total number of admissions represents .08% of the total population. This figure represents only 10% of the insane population of the country.

066 -- _____ -- GOLD COAST

Tooth, G.

Studies of mental illness on the Gold Coast
in WHO MONOGRAPH SERIES 17:141 (1953)

Refers to schizophrenia in the Gold Coast and states that among the "bush" peoples, the delusional content is almost invariably concerned with the fetish system. The fact of lunacy means that an offence has been committed either against the nature spirits, who then trouble the offender in the form of dwarfs and fairies, or against the ancestral hierarchy who appear and influence the sufferer in person. Apart from other reasons for deficient rationalizing, there is thus no requirement for this process either by the patient or his community. Literate and urban Africans on the other hand, develop delusions of the European type. These delusions are often religious, and identification with Jesus Christ or God is not uncommon. If European ancestry is claimed, as is also frequent, some explanation of the dark skin is forthcoming; and evil influences are not left in the air but arrive by "electricity" or "wireless." In general as Tooth observes, "Schizophrenia in literate Africans, was found to take very similar forms to those seen in Europeans."

067 -- _____ -- NIGERIA

Lambo, T. Adeoye

The role of cultural factors in paranoid psychosis
among the Yoruba tribe
JOURNAL OF MENTAL SCIENCE 101:239-65 (Apr. 1955)

Discusses a number of theories on the relationship between racial factors and psychological differences. Recent research has shown more and more clearly that these theories have not been borne out by the facts. The present study has confirmed the hypothesis that while the specific psychogenic factors engendered by different cultures may vary and the psychopathology of individuals

may reflect the traditions of their society, generally speaking, the fundamental basis of most mental disorders are incomparable so far as we can account for their mechanisms in terms of common psychodynamic formulations. This paper also shows that when the social and cultural environments of two racial groups become similar (as it is in the Westernized Yoruba and the Europeans), their normal and abnormal mental reactions show similar phenomena.

It has been said by some investigators that paranoid schizophrenia is not as prevalent in the primitive society as the catatonic subtype. Paranoia, paraphrenia and even paranoid schizophrenia are relatively rare in Africans, according to other research ethnic scientists. The present writer's experience has not confirmed this finding among the Yoruba tribe. Furthermore, Dr. Lambo points out that the distribution of all the subtypes of schizophrenia does not vary among the Westernized and the primitive (non-literate rural) subgroup.

The author states that intensive study and an analysis of a body of clinical materials from a specific (primitive) culture is still needed to validate some of the interesting hypotheses that have been advanced by various investigators before definite conclusions can be made. However, there is no doubt that paranoid schizophrenia and paraphrenia might be ubiquitous, but cultural factors play a role in its clinical manifestation and, therefore, have a strong bearing on the entire management of the patient.

068 --

Lambo, T. A.

Some unusual features of schizophrenia among primitive people

WEST AFRICAN MEDICAL JOURNAL 6:147-57 (1957)

Calls attention to observations made on schizophrenics among the rural population of the Yoruba tribe of Southwestern Nigeria. Data collected were confined to disturbances of affect, perception and thought. Consequently, the symptoms of the acute phase have received detailed study. An attempt is made to analyze the individual symptom and its influence upon the nature and quality of the illness. Culturally, Southwestern Nigeria is homogeneous and Yoruba social institutes are rich in emotional life with emphasis on family and group inter-

action. The author has confined himself to the psychoneurotic-like features which often dominate schizophrenia in these patients. Unusual features encountered were phasic changes, confusional episodes, twilight states, and affective exaggeration. In comparison with other endogenous psychoses the atypical and heterogenous symptom-complex exhibited the greatest predilection for the schizophrenic group as a whole. Affective exaggerations were manifested as emotional lability and incoherence, hypomanic signs characterized by hypereroticism, lack of inhibition, expansive ideation and overactivity. During twilight states there was marked confusion of thought, disturbance of association, illusions and hallucinations with manifest anxiety. Hysterical conversion symptoms include aphonia and deafness. In over 45% of cases, frank clinical expression of schizophrenia was colored by these psychoneurotic symptoms and would seem to be symptoms of the acute stage. Oddities in the pre-morbid personalities of these patients were elicited. Most of them had previously suffered from brief episodes of culturally sanctioned hallucinations and delusions. Of 20 chronic schizophrenics, admitted to Iantaro Hospital, Abeokuta, within the past 5-10 years, a careful history showed that only 14 mastered this psychoneurotic-psychotic overlap at the onset. Premorbid personalities of 9 were noticeably odd and 2 practiced "IFA", a form of cult, integrating to schizophrenia.

The main clinical interest of practical importance is one differentiation between this group with a typical prodromal phase and the group in which the phase is lacking. In most primitive cultures latent and compensating schizophrenia usually get overlooked, especially when abnormal behavior is devoid of aggression or antisocial trends. Consequently, schizophrenic patients who are brought to town clinics or picked up in the streets or market places invariably show a clear-cut clinical picture without these unusual features.

069 -- MULTICULTURAL -- AFRICA, ASIA, AUSTRALIA, EUROPE, MIDDLE EAST,
NORTH AMERICA, SOUTH AMERICA

Wittkower, E. D.; Murphy, H. B.; Fried, J. and Ellenberger, H.
Cross-cultural inquiry into the symptomatology of schizophrenia
ANNALS OF THE NEW YORK ACADEMY OF SCIENCE 84:854-63 (Dec. 8, 1960)

Calls attention to a study based on answers to a questionnaire used as a tool for collection of data concerning cultural relationships to schizophrenia. The authors wish

to emphasize that this collected data, embracing 87 patient samples or "cultures" received from 37 respondents in 25 countries, goes far beyond the boundaries of one cross-cultural study. Hence they refer to the present objectives and results as being "transcultural" rather than "cross-cultural." Having established a network of correspondents that virtually spans the whole world, the answered questionnaire became the vehicle for research into cross-cultural schizophrenic symptomatology. By and large, these investigators were well aware of the enormity of their task and the shortcomings of a mailed questionnaire. They had to face and overcome many fallacies and other potential sources of error. The areas covered by the questionnaire comprised observed clinical schizophrenic symptomatology from the following cultural sources:

Africa -- Kenya, Nigeria, Uganda, Union of South Africa
Asia -- Formosa, Hong Kong, India, Thailand, Japan
 (Okinawa), Korea (South)
Australasia -- Australia, New Zealand
Europe -- Bulgaria, Czechoslovakia, Norway
Middle East -- Kuwait, Turkey
North America -- Canada, United States
South America and Caribbean Islands -- Brazil, Columbia,
 Ecuador, Peru, Barbados, Martinique

The following comprises a listing of schizophrenic symptoms furnished to the respondents for scoring of the cultural groups under their observation. A global view shows that psychiatrists over the world regard social and emotional withdrawal, hallucinations and delusions, and flatness of affect as pathognomonic of schizophrenia.

(MULTICULTURAL -- contd.)

DELUSIONS

- (1) Grandeur
- (2) Jealousy
- (3) Persecution
- (4) Religion
- (5) World destruction
or redemption

HALLUCINATIONS

- (1) Auditory
- (2) Visual
- (3) Olfactory
- (4) Tactile

HYPOCHONDRIACAL IDEAS

SOCIAL AND EMOTIONAL WITHDRAWAL

DISTURBANCES OF AFFECT

- (1) Flatness
- (2) Inappropriateness

CATATONIC STATES

- (1) Stereotypy
- (2) Mannerisms
- (3) Negativism
- (4) Stupor
- (5) Automatic obedience
- (6) Echolalia
- (7) Echopraxia
- (8) Rigidity
- (9) Excitement

LOSS OF CONTROL

- (1) Of bladder
- (2) Of bowel
- (3) In masturbation
- (4) In temper outburst
- (5) In sexual assault
- (6) Homicidal
- (7) Suicidal

DEPERSONALIZATION OR REALIZATION

The patient samples or "cultures" were often not strictly those that a cultural anthropologist would call cultural entities, but they were obviously distinct enough to be regarded by the reporting psychiatrist as separate entities with distinguishable sociocultural features. As regards comparability, it was necessary to take into account that the reporting psychiatrists were from different cultures, that their training, clinical concepts and working conditions varied as well as their understanding of the people with whom they work.

070 -- _____ -- INDIA, JAPAN, CHINA, THAILAND AND NEPAL

Kelman, H.

Psychotherapy in the Far East

PROGRESS IN PSYCHOTHERAPY 4:296-305 (1959)

States that to properly understand psychotherapy in the Far East, the psychiatrist must have some appreciation of the East's rapid Westernization, particularly its impact on the individual and the family, together with a knowledge of its social, cultural and religious patterns. In the present paper, Dr. Kelman reports on psychotherapy

in Hong Kong and in four Asian countries: Japan, Thailand, India and Nepal. Throughout the Far East, the author sensed an overwhelming preoccupation with the subject of schizophrenia. It not only dominated public discussions but private meetings as well. An interesting feature of this geographical study is his treatment of psychotherapy in Thailand. This country, per capita, has more public and private psychotherapy than any other country in East and Southeast Asia. The Thai are greatly concerned over the incidence of schizophrenia in their country; 72% of their hospital patients are schizophrenic. Almost all psychiatrists there have office hours after hospital practice. With a population of 20,000,000, Thailand has more mental hospital beds, the best residency program, more medical students and three of the best medical schools in the Far East. Western observers have noted 3 factors that are apparently related to the high incidence of schizophrenia in Thais: (1) The inherent Thai culture, which seems to play a part in producing a schizoid personality; (2) certain customs which teach a quiet life and which induce a lack of drive or aggressiveness; and (3) mother-child relationships and child training, which instill regressive reactions in psychosexual development. Nepal, on the other hand, stands as a direct antithesis to Thai. It has but 80 physicians and no psychiatrists for a population of 8 million people. Nepal forcibly reminds us that for psychiatry to exist, there must be a ruling class that cares, enough funds, enough education, enough doctors, and enough public enlightenment.

071 -- _____ -- ITALY, ENGLAND AND U. S.

Parsons, Anne

Some comparative observations on ward social structure:

Southern Italy, England, and the United States

L'OSPEDALE PSICHIATRICO 2:23 pp. (Apr.-June 1959)

Summarizes ward social life and general behavior of schizophrenic female patients in a mental hospital located in Naples. The author's findings are compared to those found in American and English institutions. (a) Aggressive behavior: This type of conduct is much more common in Italian institutions than in American or British hospitals. The aggressive behavior elicited from the Neapolitan patient usually takes the form of elaborate verbal insults. (b) Repetitive pleading: Pleading to go home (almost to the point of echolalia) is a major performance for patients in the Neapolitan hospital. (c) Physical contact: Unlike

the English and American counterpart, the hospitalized Neopolitan shows a minimal aversion to physical contact. Only when the contact is overtly sexual do nurses and patients express disapproval. (d) Delusions and hallucinations: In contrast to American state hospitals, the Neopolitan patient rarely shows highly elaborate delusions and ways of expression are minimal. Paranoid ideas and feelings of persecutions by family members and neighbors as well as magical ideas are quite similar to commonly held social ideas in the normal population. (e) Social isolation: The Neopolitan ward society has a marked atmosphere of sociability and motility, while the non-industrialized society of Naples produces schizophrenics of a less bizarre or isolating type. It nevertheless produces this severe mental illness so that etiological explanations of some sociological or anthropological writers of the 1930's, linking the disease to industrialized and highly differentiated societies, are highly inaccurate. Social factors alone cannot explain the genesis and course of schizophrenia.

072 -- _____ -- NEW GUINEA, OKINAWA, BRAZIL, FORMOSA, SOUTH AFRICA, INDIA

Carstairs, G. M.

Some problems of psychiatry in patients from alien cultures
LANCET 1:1217-20 (June 7, 1958)

Deals with the myth of psychosis-free cultures along with a number of other psychiatric problems in patients from alien cultures. Faris (1937) believed schizophrenia to be non-existent among the forest Bantu and Seligman (1929) thought it unknown in New Guinea. Still another investigator, Lopez (1932), announced that none was to be found in the Brazilian interior. Laubscher (1937) found, however, that there was no lack in mental illness among the Cape Bantu and deemed schizophrenia their most common form of psychosis. The myth was revived by Maloney in 1945 in favor of the Okinawans, but in 1952 Wedge showed that the rates for psychotic breakdown were higher in Okinawans than in any other immigrant groups in Hawaii. On Formosa, Lin (1953) found prevalences of the major psychoses which are very similar to those seen in European populations. Carothers (1953) and Laubscher (1937) remarked on the rarity of psychotic depressions in Africans in Kenya and South Africa respectively. In a true prevalence study, not dependent as were the other observations on hospital admission figures, Lin (1953) showed the ratio of schizophrenic to manic depressive cases,

which is about 3/1 in European surveys of this kind, falls to $2\frac{1}{2}$ /1 in his Formosan population. (On the other hand, alcoholism and psychopathy were unknown in Formosa.) Such population ratios are for the most part governed by culture, and diagnosis for the established condition. An exception to this generalization is that in West-Africans organic psychosis, especially that due to trypanosomiasis can easily be mistaken for schizophrenia (Tooth -- 1950). By and large, diagnosis is not too difficult for the gait, the posture, the expressive movements of a catatonic, a manic, or a melancholic patient have a remarkable similarity, whether he be a Japanese, an Indian, a Dutchman, or a Scot.

073 -- _____ -- SARAWAK, BORNEO, CHINA, SEA DYAKS, EUROPE AND EURASIA

Schmidt, K. E.

Management of schizophrenia in Sarawak Mental Hospital (1959)
JOURNAL OF MENTAL SCIENCE 107:157-60 (Jan. 1961)

Gives results of management of schizophrenic patients at the Sarawak Government Mental Hospital. This hospital is the only one of its kind in Sarawak for a population of 700,000 plus 70,000 of the Sultanate of Brunei. By and large, this constitutes the only accommodations (350 patients) for the entire area, plus British North Borneo. In 1959, there were 338 admissions. Out of these, 202 (57%) can be placed into the diagnostic group of schizophrenias, 54 of whom were readmissions. The country lies just north of the equator. The cultural population comprises: 220,000 Chinese (213); 210,000 Sea Dayak (38); 170,000 Malay (62); 30,000 Land Dayak (7); 70,000 Melano, Kayan, Kenyah, Kelabit, Murut, Punan, Bisaya, Indian, Eurasian, and European (18). The figures in parenthesis are the shares these groups take in hospital admissions, which leaves much room for thought.

From the methods of therapy described herein, one gets the idea that the best type of schizophrenia as regards prognosis is social isolation, i.e., lack of visitors; it appears that the productive forms can be quickly treated and discharged. They may have further relapses and need readmission; that is, hebephrenia, paranoid schizophrenia, and the productive phases of catatonic schizophrenia. The unproductive forms seem to be of worse prognosis; that is, simple schizophrenia and unproductive catatonia. As regards treatment, the newer methods deal effectively with the first group of this dichotomy of schizophrenia but appear to be ineffectual

in the second, i.e., those patients where lack of drive is the outstanding feature (as is also seen in the chronic stage). Dr. Schmidt says that so far his experience with the newer anti-depressant drugs has been disappointing in those patients who need "activation."

074 -- _____ -- Thailand, U.S.S.R., India, Japan, Africa

Wittkower, E. D. and Fried, J.

A cross-cultural approach to mental health problems
AMERICAN JOURNAL OF PSYCHIATRY 116:423-28 (Nov. 1959)

Considers the cross-cultural approach as an excursion into the field of social psychiatry. One investigator (Opler) conceives social psychiatry as invariably involving the complicated play of interpersonal relations between sets of individuals at the same time viewing the behavior of such individuals against the background of, in interaction with, and in response to their socio-cultural environment. The data summarized in this paper have come predominantly from correspondence with psychiatrists and social scientists abroad, strategically placed and qualified to give authoritative information.

The author poses several questions concerning the cross-cultural aspects of mental health problems. He attempts to answer these queries, one of which is: "Are there any significant differences in the prevalence and incidence of mental disorders in different cultures?" Dr. Wittkower points out that these differences are largely based on rates of mental hospital admittance and, therefore, are open to objection. For instance, Ratanakorn states that admissions with schizophrenia amount to 72% in Thailand as against 28.8% in the U.S.S.R. Other statistics are given in response to this question.

Another question which arises is "Are there any nosological differences in the manifestations of mental disease on comparison of different cultures?" The example of schizophrenia is given. Observers with psychiatric experience in the East and in the West have noted that hospitalized schizophrenic patients are less aggressive and less violent in India and in Japan than schizophrenics in western mental hospitals. It was also noted that Japanese schizophrenics maintain contact with other human beings more than patients in the United States. Schizophrenia in African natives is said to be quieter and less florid -- a poor imitation of western forms.

Still another question that the author answers is "Are there any particular syndromes which are specific to certain geographical areas or cultural confines?" A number of such syndromes are described as Koro, Latah, Imu, Arctic hysteria, Young-da-hte, Hsieh Ping, Susto, and Windigo psychosis. Each of these syndromes are described in the text.

Divergent views have been expressed regarding the relevance of Oriental cultures to the incidence of schizophrenia. It has been suggested that the Eastern way of life (a) predisposes to schizophrenia, (b) conceals it in prizing and rewarding schizoid trends and (c) safeguarding against it by providing an outlet for introvert tendencies. Beyond this, it is observed that the content of schizophrenic delusions is conditioned by culturally patterned orientations and that their paucity or richness reflects the modalities of mental or behavioral activities inherent in diverse cultural systems.

075 -- JUDAISM

Sanua, Victor D.

Family environment and schizophrenia

McGILL UNIVERSITY REVIEW AND NEWSLETTER (Montreal) 9:22-26
(Dec. 1960)

Presents, in a review of a 31 page mimeographed paper, a critical discussion of some of the studies on parent-child relationships in schizophrenia. The paper contains preliminary data on the characteristics of the home environment of two religious groups (Protestant and Jewish) with schizophrenic members and where the social class variable has been controlled. The general hypothesis is that early unfavorable home environments affects the psychological adjustment of the individual. One of the recurrent findings in schizophrenia and other mental conditions is to relate the type of home environment with the specific illness or deviance.

By and large, schizophrenic patients in most instances have had an unwholesome relation with their mothers. Some are found to be over-protective, rejecting, domineering, aggressive, etc. The father, on the other hand, is usually weak and submissive. Dr. Freida Fromm-Reichmann coined the descriptive phrase, "Schizophrenogenic mother." The qualifying term has rarely been applied to the father. The inconclusiveness of the studies reported in the literature may be attributed to the fact that in most instances, the socio-cultural variables which characterize the families of the schizophrenics studied were ignored.

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